BACKGROUND ON CPP AND PRIVATE DISABILITY INSURANCE

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Background on CPP Disability and Private Insurance

The relationship between CPP disability and the private disability insurance industry

Introduction

Private disability insurance is the most likely additional source of disability income received by CPP disability recipients. According to a 1995, Statistics Canada survey conducted for Human Resources Development Canada ("HRDC"), approximately 25 percent of CPP disability beneficiaries received benefits from private insurers, 17 percent from workers compensation plans, and 13 percent from social assistance benefits. Together, more than 60 percent of CPP disability beneficiaries receive disability income from another income security program.[1]

Given the prominence of private disability insurance as an income support for CPP disability recipients, it is appropriate to explore private disability insurance, the insurance industry, and how the public and private systems interact in order to better understand the relationship between the two forms of disability benefits.

The link between CPP and private disability insurance

CPP disability benefits alone are not sufficient to provide the sole source of income support or earnings replacement for beneficiaries. There are statutory limits on the level of CPP benefits. The Canada Pension Plan is designed to replace approximately 25 percent of one's yearly maximum pensionable earnings ("YMPE"). YMPE is an amount equal to the average industrial wage; in 2001, the maximum level of disability benefit allowed was $11,221. The assumption is that CPP benefits will be supported by other forms of earnings replacement.

CPP as "first payer"

The CPP disability benefit is viewed as the "first payer" by most private insurance plans and by an increasing number of provincial workers' compensation programs. This means that other program benefits are not taken into account when calculating the amount of CPP disability benefit and conversely,

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[1] *1996 Report of the Auditor General of Canada* (Ottawa: Queen's Printer, 1996) at 17.116.

that other insurance plans may take CPP disability benefits into account when calculating a claimant's entitlement to benefits. It is important to note that there is no express statutory basis for this view, merely a presumption resulting from how CPP is calculated. The Auditor General assessed eligibility for the CPP disability benefit in 1996 and reaffirmed this presumption in his analysis:

> The Canada Pension Plan contains no provision concerning the treatment of disability benefits from other sources, other than provisions allowing for reimbursement of advances paid by other plans. As other programs' benefits are not taken into account, this makes the Plan a first payer.[2]

Others assert that this concept of "first payer" is also consistent with the original intent of the Canada Pension Plan, which was to take into account CPP's relationship with other payers, including private insurers, and to be just one component of a multi-tiered pension system.[3]

Most private long-term disability replacement plans are integrated with CPP benefits by providing that private benefits, in addition to any other benefits received, must not exceed a stated percentage of a beneficiary's normal earnings.[4] This integration occurs regardless of whether the total income that the beneficiary would receive from private disability insurance derives entirely from the insurance company or a combination of CPP and private insurance top-up. Private insurance companies have also stated that premiums are actuarially adjusted to take into account the fact that it acts as second payer and that premiums would be higher in the absence of CPP.[5]

Most private insurance companies require insureds wishing to make a claim for CPP disability benefits to apply for CPP disability and to appeal a denial. Many agreements also indicate that noncompliance with these terms will result in withholding or reduction of long term disability benefits by the estimated amount of the CPP disability benefit. This appears to be a standard practice and part of standard form agreements of most private insurance policies. (See Appendix "A")

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[2] *Ibid.* at 17.132.

[3] S. Torjman, "Read the Fine Print" (April 2001) Caledon Commentary at 4

[4] *Canadian Life and Health Insurance Facts, 2001* (Toronto: CLHIA, 2001) at 13.

[5] *Supra,* note 3.

CPP legislation permits integration of benefits

The *Canada Pension Plan*[6] expressly permits integration of benefits between public and private insurance. Section 65. (3) of the Act and section 76.1 of the Regulations provide for the assignment of retroactive lump sum disability benefits to government agencies and insurance companies under agreements in which a person is found to be eligible for both CPP benefits and private insurance and the plans are integrated. Under these "agreements," the CPP disability 'amount' of the benefit is paid in advance by the insurance company, who is deemed an "Administrator of a Disability Income Program," then 'reimbursed' once the CPP disability claim is payable.[7] This amendment to the Act and to the Regulations was enacted June 1,1993 and has resulted in a number of agreements with private insurance plans pursuant to this provision.

The uniform legislation[8] permits integration of benefits

The uniform legislation upon which provincial/territorial private insurance is based, sets out statutory conditions which must form part of every contract of insurance. The uniform legislation contains provisions which allow for/assume coordination of benefits between various income replacement programs.

Condition 4 under section 300 of the *Insurance Act*[9] of Ontario provides for the partial coordination of benefits where an insured is entitled to benefits under more than one contract of disability insurance. This condition applies to disability insurance only when it forms part of an accident and sickness policy and to policies which pay benefits calculated as a proportion of the insured's pre-disability income. It states that where the cumulative benefits exceed the insured's pre-disability income, the insurer is liable to pay only a proportionate share of the total benefits to which the insured is actually entitled and that any excess premium is to be refunded.

This provision ensures that a disabled insured will *never* receive benefits that will be greater than

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[6]*Canada Pension Plan*, R.S. 1985, c. C-8.

[7]Note that the only significant condition of the agreement is that the Administrator of the disability income program does not offset the benefit paid by the CPP disabled contributors' Children's Benefit.

[8]"Uniform legislation" refers to the model insurance legislation that has been adopted in all of the common law provinces and territories governing life insurance and accident and sickness insurance.

[9]*Insurance Act*, R.S.O. 1990, c. I.8.

a predetermined proportion of his/her income, despite that insured's potentially legitimate qualification for benefits under a number of disability programs.

Section 299 of the Ontario *Insurance Act* states that, subject to section 300, the insurer must set forth in the policy every exception or reduction affecting the amount of benefits payable. An insurance agent's failure to properly explain the effect of an integration of benefits provision may constitute negligence for which the insurance company is liable.[10]

There are no legislative criteria governing how income should be defined under private insurance policies. In addition to workers' compensation and CPP disability, some plans deduct spousal earnings as household income. Some private insurance companies deduct the CPP Child's Benefit as household income. This treatment of the CPP children's benefit has been identified as contrary to the purpose of the benefit. The legislative purpose behind this provision, which provides an indexed, flat-rate benefit, was to provide additional income support to assist families where the contributor has become disabled and unable to work. It was a recognition by government that basic household needs may not be met when a contributor becomes disabled and unable to work. By deducting this benefit, the insurance companies are treating it as earnings replacement, not income support.[11]

Harmonization of CPP and workers' compensation

There is limited, but increasing harmonization of CPP disability with other public income security programs, such as workers' compensation. It is possible to receive both CPP disability and workers' compensation because eligibility for CPP is not dependant upon a work-related cause, as it is for workers' compensation. Workers' compensation also may provide partial benefits for partial loss of capacity, unlike CPP.

Most workers' compensation programs initially regarded themselves as first payers. Some provinces now harmonize their programs with CPP. Ontario's workers' compensation legislation, the *Workplace Safety and Insurance Act, 1997*[12] takes CPP disability payments into account in calculating payments for loss of earnings, i.e., it treats CPP as the "first payer."

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[10]See *Theophanous* v. *Mutual of Omaha Insurance Company*, [1991] I.L.R. 1-2718 (Ont. Gen. Div.).

[11]Torjman, *supra* note 3 at 5.

[12]S.O. 1997, c. 16, Sched. A, s. 43(5).

There is no consistency of approach across the country with respect to harmonization of workers' compensation with CPP disability. Some provinces' workers' compensation boards remain as first payer (Alberta), while others deduct percentages of CPP ranging from 50 percent (Saskatchewan) to 100 percent (Ontario and Manitoba) from workers' compensation benefits.

Between June 1998 and March 1999, HRDC entered into exchange-of-information agreements with five provincial workers' compensation boards. The agreements provide for the payment to the boards of retroactive benefits due to beneficiaries, where such amounts are to be recovered by the boards, under the assignment of benefits clause in the *Canada Pension Plan*.[13]

The significance of CPP as "first payer"

There are broader issues raised by CPP's role as "first payer" and the resulting integration and harmonization of other forms of disability income, both practical and philosophical:

1) What is the effect of integration or harmonization of benefits on the total level of benefits available to the disabled?

2) What is the effect of increasing integration of benefits on the nature of the disability insurance contract itself?

3) Is there a philosophical distinction between harmonization of two public programs versus harmonization of a public program and a private program?

Effect of integration/harmonization on level of benefits

Clearly, integration has the effect of limiting the overall level of disability benefits available to claimants. It has been justified by the argument that, without integration, it would be possible for a disabled individual to receive benefits which would equal or exceed his or her pre-disability employment income. This is an issue beyond the scope of this analysis, but it is one that should be debated. What amount of benefits should a recipient who qualifies, receive, and who should determine this?

Understanding how integration affects the level of benefits requires understanding the tax treatment of various forms of income support. Where the employer has paid all or a part of the cost of coverage of a wage loss replacement plan, a periodic benefit for disability will be taxable as income. Where the entire cost is borne by the employee, the benefit is not considered income and therefore, not taxed.[14] CPP disability benefits are fully taxed because both the employee and the employer contribute.

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[13] *Report of the Auditor General of Canada* (Ottawa: Queen's Printer, 1999) at 32.79.

[14] *Income Tax Act*, R.S.C. 1985, c. 1 (5th Supp.), s. 6(1)(f); IT-428, "Wage loss replacement

(Self-employed contributors are deemed to contribute as employer and employee and are fully taxed.) Workers' compensation benefits must be included as income but are fully deducted from tax.[15]

It is important to note that CPP benefits which are assigned to an "administrator" under the integration provisions of the CPP Act and regulations, discussed above, are still fully taxed to the beneficiary even though they are directly assigned to the insurance program and never received by that beneficiary.

From the perspective of the claimant, the greater the amount of the benefit derived from CPP in combination with private insurance (where the employer has contributed to the plan), the lower the overall level of benefit and the greater the tax consequences to the claimant. In those jurisdictions where workers'compensation acts as the first payer and does not deduct CPP, a claimant who qualifies for workers'compensation will receive higher benefits that will not be taxed.

Many disabled may not be sufficiently disabled to meet the CPP definition of disability and/or cannot meet the contribution requirement for CPP, but private insurers will still take the CPP benefit *into account* in setting the level of benefits available, even in situations where CPP entitlement is not established and therefore not directly deducted. (See example, Appendix "B")

Effect of integration/harmonization on the contract itself

Hayles[16] suggests that the proliferation of 'coordination of benefits' clauses in disability policies which list the specific income replacement payments that are to be deducted from the benefit payable and the common practice of calculating benefits as a portion of earnings, have moved these policies from non-indemnity contracts to indemnity contracts.

Benefits under life and disability policies have traditionally been viewed as non-indemnity contracts. Benefits are paid upon proof that the event insured against had occurred, with no requirement of proof of actual financial loss. Indemnity contracts are understood as contracts in which the insurer agrees to compensate the insured for financial losses arising out of the insurance risk. They require proof of actual financial loss, such as property or automobile insurance. Given the nature of the physical object

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plans" (April 30, 1979).

[15] *Ibid*, ss. 56(1)(v); 110(1)(f)(ii).

[16] R. Hayles, *Disability Insurance: Canadian Law and Business Practice*, (Toronto: Carswell, 1998) at 268 and 277.

being insured, the focus of attention on financial loss is more self-evident under these types of contracts, than under life and disability insurance.

This transformation in treatment of disability insurance from a non-indemnity contract to an indemnity contract results in a shift in emphasis of the policy which has important consequences for the insured. The result to beneficiaries is a lowering of benefit levels overall under private disability policies. There is also an onus placed on disabled beneficiaries to participate in this integration of benefits by being obliged to apply for and/or appeal CPP disability and to understand how this complex interaction of benefits and their tax treatment will affect the beneficiary's overall level of replacement income.

This significant change in treatment by insurance companies of disability insurance contracts raises a critical question: Is this how we should be envisioning disability insurance?

Impact of harmonization on the concept of disability insurance

It could be argued that it is appropriate that publicly-based income security programs harmonize the benefits payable for similar causes. Where a disability arises from a work-related injury, there would appear to be an inherent logic for workers' compensation to act as the first payer. But are there philosophical consequences if CPP became the second payer in relation to other public income support programs such as workers' compensation? Some have suggested that there is a risk that CPP's status as a universal program will be eroded: "Turning CPP into a second payer could make it a residual program rather than an insurance that provides guaranteed coverage for all who have made the required contributions."[17]

Québec has its own pension plan legislation and a very different regime in terms of treatment of disability. In Québec, workers' compensation and the QPP disability are considered mutually exclusive programs. The Québec workers' compensation program, le Commission de santé et de sécurité au travail, is the first payer in relation to QPP disability and is, in fact, the only payer. Persons with employment-based disabilities may receive financial assistance from workers' compensation or QPP disability, but not both. Québec appears to have historically directed more of its disability caseloads to social assistance than to QPP, although this might be changing as a result of financial pressures on a program such as social assistance, which is fully funded by government.[18]

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[17]S. Torjman, "The Canada Pension Plan Disability Benefit" (February 2002) Caledon Institute of Social Policy at 52.

[18]*Ibid.* at 41.

The private insurance industry

Insurance companies have the same legal status as other corporations in Canada. They have the capacity, rights, powers and privileges of a natural person (section 15 of the *Insurance Companies Act*[19]). A federally incorporated insurance company can carry on business anywhere in Canada and can do business in any foreign jurisdiction, subject only to the laws of that jurisdiction. The corporate governance of insurance companies is also similar to that of private corporations. They may implement plans of internal organization similar to that available to other federally incorporated companies.

The life and health insurance industry in Canada has become a broadly-based, highly competitive, financially powerful and influential industry. At the end of the year 2000, the Canadian Life and Health Insurance Association Inc. ("CLHIA"), the nonprofit organization of member life and health insurance companies in Canada which administers the self-regulation by the industry, reported that the Canadian private life and health insurance industry had more than $267 billion in assets.[20]

The industry plays a significant role in sustaining the finances of three levels of government through its security holdings ($25.1 billion in federal securities, $29.4 billion in provincial securities, $2.7 billion in municipal securities). It has substantial investments in foreign markets: $49.1 billion or 55 percent of premiums are generated from foreign markets.[21]

After ten years of consultation with the insurance industry, a new legislative scheme was enacted in the early 1990s, the *Insurance Companies Act*.[22] This Act allowed the industry to diversify and expand both its investments and business activities. The insurance industry may invest assets in real estate, mortgages (residential and commercial), mutual funds, stocks and bonds (corporate and government). It can engage in business activities which include: investment counseling services, portfolio management, issuing and operating credit card plans in cooperation with banks or trust companies, operating real estate brokerages and dealing in real property.

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[19] *Insurance Companies Act*, S.C. 1991, c. 47.

[20] Canadian Life and Health Insurance Association Inc., *Canadian Life and Health Insurance Facts, 2001* (Toronto: CLHIA, 2001) at 2.

[21] *Ibid.* at 2-3.

[22] *Insurance Companies Act*, S.C. 1991, c. 47, ss. 440-441; 490-514.

The purpose of the few restrictions which are placed on insurance company activities is to preserve the (thinning) distinction between insurance companies and banks or trust companies. As a result, an insurance company cannot act as executor or administrator of an estate or as trustee of a trust, or accept deposits.

Paralleling this growing incursion of the insurance industry onto the terrain of financial institutions, has been increased demands placed on government. The CLHIA has lobbied the federal government for public policy changes to allow the industry to compete with deposit-taking institutions. In a 1997 submission to a federal task force on the Canadian financial services sector, the CLHIA stated:

> The public policy framework continues to be characterized by a number of policy induced competitive inequities that disadvantage life and health insurers relative to deposit-taking institutions. A prime example is the access to the Consolidated Revenue Fund and the Crown guarantees enjoyed by CDIC in contrast to the industry's CompCorp,[23] which has neither. Moreover, the industry's exclusion from the national payments system is an example of a level playing field anomaly that detracts from the quality of competition.[24]

Although beyond the scope of this analysis, this raises an interesting question as to whether an industry which is essentially self-regulated, should have access, as a publicly funded and regulated government program would, to the Consolidated Revenue fund (the general pool of all income of the federal government).

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[23]CompCorp is an insurance company organized and financed by the industry to compensate beneficiaries of life and disability policies of member companies, who are unable to collect as a result of the insolvency of a member company.

[24]Canadian Life and Health Insurance Association Inc., "Canada's Life and Health Insurance Industry: Structural and Business Powers Framework. Submission to the Task Force on the Future of the Canadian Financial Services Sector" (October 1997) .

The private disability insurance contract

The private insurance contract is a standard form contract. This means that the issuance, delivery and often the terms of disability insurance policies are governed by uniform legislation. This legislation was developed by the Superintendents of Insurance of the provinces, in a series of federal-provincial conferences held in 1914, in response to a consensus that the growing insurance market needed to be regulated.

Two kinds of uniform legislation were developed in relation to 'insurance of the person': life insurance legislation and accident and sickness uniform legislation. With minor variations, this uniform legislation is in place in all the common law provinces and territories today.

The model life insurance legislation is found in Part V of the Ontario *Insurance Act*. It applies to disability insurance provided in a life policy. The model accident and sickness insurance legislation is found in Part VII of the Ontario *Insurance Act* and it applies to disability insurance when it forms a part of an accident and sickness policy. One needs to know how an insurance policy is classified in order to know what part of the Act it falls under and the classification depends on extent of death benefit provided in the policy.

This distinction is important. For example, section 184 of the Ontario *Insurance Act* states that the incontestability rule does *not* apply to disability insurance in Part V of the Act. The incontestability rule is stated in subsection 184(2):

> Subject to subsection (3), where a contract has been in effect for two years during the lifetime of the person whose life is insured, a failure to disclose or a misrepresentation of a fact required to be disclosed by section 183 does not, in the absence of fraud, render the contract voidable.

This means is that where disability insurance is part of a life insurance policy (not an accident and sickness policy), the insured is *not* protected by the incontestability rule and the insurer may void the contract at any time due to the insured's failure to disclose or due to misrepresentation by the insured. This is a distinction that could have a significant impact on a beneficiary.

Insurance contracts are "Utmost Good Faith" contracts

Insurance contracts are generally considered to be contracts of "Utmost Faith," requiring both parties to do more than merely perform the obligations written into the contract itself. "Utmost Faith" connotes a mutual obligation of absolute honesty or trust. It recognizes that both the insurer and the

insured are dependent on the integrity and goodwill of the other. At the outset the person being insured holds the power, as the insurer is accepting a risk about which it knows very little. Once the contract is in place the power shifts to the insurer, particularly when a claim arises and the insured is injured or ill and cannot work, and is therefore dependent upon the insurer for income.

Disability insurance contracts have also been described as "Peace of Mind" contracts. *Warrington* v. *Great-West Life Assurance Co.*[1] concerned a dispute over payment of benefits under a disability insurance policy. The B.C. Court of Appeal considered whether a disability insurance contract was a "Peace of Mind" contract which it defined as:

> Thus the door was opened for recovery in at least a category of cases often called "peace of mind" cases - i.e., situations in which freedom from mental distress or even actual enjoyment was the very thing contracted for and not provided.[2]

The Court affirmed that a contract of this kind was a "Peace of Mind" contract, by considering the effect of the insurance company's refusal to pay the benefits owed to Warrington under the terms of the contract:

> His illness was one that is likely exacerbated by stress. It seems to me that this is exactly the type of mental distress and inconvenience one buys disability insurance to avoid - in other words, that the *object* of this contract was Mr. Warrington's comfort or peace of mind.[3]

The Court also stated that the nature of disability contracts may give rise to aggravated damages. It held that a disability insurance policy is one of the few contracts in which damages for mental distress are recoverable when they result from the breach of the contract itself.

The importance of the concept of the duty of good faith and "peace of mind" in insurance contracts was reaffirmed recently by the Supreme Court in the case of *Whiten* v. *Pilot Insurance Co.*[4] The case involved a dispute over payment of a claim under a property insurance contract, but it also

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[1] *Warrington* v. *Great West Life Assurance Co.*, [1996] 39 C.C.L.I. (2d) 116n (B.C.C.A..).

[2] *Ibid.* at 127.

[3] *Ibid.* at 131.

[4] *Whiten* v. *Pilot Insurance Co.*, [2002] S.C.C. 18.

concerned the concept of good faith and fair dealing implied in contracts of insurance. The Court reaffirmed these principles in upholding a jury's high award of punitive damages for breach of contract by the insurance company:

> Insurance contracts, as Pilot's self-description shows, are sold by the insurance industry and purchased by members of the public for peace of mind. The more devastating the loss, the more the insured may be at the financial mercy of the insurer, and the more difficult it may be to challenge a wrongful refusal to pay the claim. Deterrence is required. The obligation of good faith dealing means that the appellant's peace of mind should have been Pilot's objective, and her vulnerability ought not to have been aggravated as a negotiating tactic. It is this relationship of reliance and vulnerability that was outrageously exploited by Pilot in this case. The jury, it appears, decided a powerful message of retribution, deterrence and denunciation had to be sent to the respondent and they sent it.[5]

Group insurance and the group policy

Group insurance arises where a policy is issued to an insured who is not an individual (unlike individual insurance) and who may or may not, be responsible for payment of premiums. Group insurance may take many forms. The insured is often a company, entering in on behalf of its employees, or a union, professional association, or an alumni organization. Banks and trust companies may offer group coverage to their mortgagees. Finance companies may enter into arrangements with insurers to provide disability and life coverage upon the financing of major consumer purchases, such as automobiles. Retailers and credit card issuing financial institutions may also offer group coverage to cardholders. Any organization which has the legal capacity to contract and which is in sufficiently close association with an identifiable group of individuals may qualify, as long as the group was formed originally for a purpose other than insurance coverage.[6]

The issuance of a group policy or master policy creates a plan under which insurance is offered members of the group. The policy defines the group so that the insurer and the insured (the policyholder) may later determine whether or not an individual who applies for coverage is qualified to receive it. The master policy describes the coverage, sets out terms and conditions which will apply and may contain a formula for calculation of premiums paid by group members. The individual group insured is usually given a certificate without a copy of the master policy. The certificate is usually just a summary of terms

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[5] *Ibid.* at para. 129.

[6] Hayles, *supra* note 16 at 93.

of coverage rather than the complete certificate itself.[7]

Group insurance has a number of advantages over individual insurance. It may be more cost-effective for the insurer because it reduces marketing costs and reduces administration costs for the insurer (if the policyholder does some of the administration work). There are also advantages for the insured. There is less scrutiny of individual applicants under group insurance and therefore, a greater opportunity for more high risk applicants to be covered.[8] The insurer also provides coverage to many individual insureds at once, so the high cost of insuring poor risks is offset by the lower costs of covering healthy, low-risk members of the group.

Legal issues surrounding group insurance

There are a number of legal issues raised by the concept of group insurance because group insurance introduces an additional party to the contract, the contracting organization or company who 'holds' the policy on behalf of the individuals ensured under the policy. Many of these issues have been settled by the jurisprudence. The issue of contract formation arises under the law of contracts. What is the legal status of the group person insured? Are they a party to the contract? It has now been established that the group person is a party to the group contract.[9]

There is also the issue of agency. Is the policyholder an agent for the insurer? If so, is the insurer accountable for statements made by the policyholder to the individual insured? Judicial opinion in Canada holds that the policyholder does represent the insurer and the insurer is responsible for policyholder's dealings with the group person insured on the basis of agency.[10] There has also been limited support for the view that the existence of agency depends on whether insurer or policyholder administers the plan.

The jurisprudence has also held that the law of torts is applicable to insurance contracts, given, as described above, the special nature of insurance contracts. It has been held that an insurer may be vicariously liable for a policyholder's tortious acts or omissions. There is also the question whether the

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[7]Hayles, *supra* note 16 at 93.

[8]This may not be true in practice. See below, p. 23 for evidence that many consumer complaints arise from denial or discontinuation of disability benefits under group insurance policies.

[9]*London Drugs* v. *Kuehne & Nagel International Ltd.*, [1992] 3 S.C.R. 299

[10]*Tarailo* v. *Allied Chemical Canada Ltd.* (1989), 68 O.R. (2d) 288 (H.C.).

policyholder has a duty of care toward the group person insured, for example, with respect to negligent statements regarding the extent of coverage. There does not appear to be a consensus as to whether a duty of care also exists on the part of the policyholder and whether such a duty includes a duty to provide a complete explanation of the insurance.[11]

Oversight Mechanisms

Government oversight

Oversight of the private insurance industry and the private insurance contract is found at the provincial and federal levels of government. It is important to understand the differing jurisdictions of the federal and provincial governments over insurance companies and the insurance contract in order to know where mechanisms of change are located.

Federal oversight and federal legislation deal primarily with licensing of insurance companies, corporate governance of federally incorporated companies and insurance company investments and finances. The federal government does not deal with the insurance contract or marketing of insurance products to the public.

Provincial legislation also deals with licensing of insurance companies (those that are provincially incorporated), but primarily it has authority over the contractual relationship between the insurer and the insured. Provincial oversight includes: the enforceability and content of insurance contracts, disclosure and misrepresentation, the application of common law insurance doctrines such as insurable interest, and statutory conditions of sickness and accident policies.

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[11] *Ibid.* and see *Twardy* v. *Humboldt Credit Union Ltd.* (1985), 34 C.C.L.T. 140 (Sask. Q.B.).

Legislative/Regulatory oversight

Federal oversight

Federal statutes and regulations deal with the financial soundness, corporate organization and solvency of federally incorporated and non-Canadian companies. The primary piece of federal legislation is the *Insurance Companies Act* which deals with all aspects of incorporation, corporate finance and organization, and the financial stability of insurance companies. This legislation and its accompanying regulations contain consumer protection provisions, but it is important to note that they deal only with issues of disclosure pertaining to credit card charges or the cost of borrowing against the cash surrender value of a policy and the establishment of complaint procedures related to this type of disclosure.[1]

The Act also sets out the powers held by the Superintendent of Financial Institutions over the supervision of the financial affairs of insurance companies. The Superintendent has the power to make orders to compel a company to cease an unsafe or unsound business or financial practice or to take control of a company's assets, where it is unable to meet its liabilities or its assets are inadequate to protect policyholders or creditors.[2]

The *Office of the Superintendent of Financial Institutions Act*[3] creates the position of Superintendent of Financial Institutions and sets up the government department responsible for ensuring compliance with the federal laws applicable to insurance companies and other financial institutions. It is important to note that the objects of the Office of the Superintendent with respect to financial institutions are solely directed to monitoring and ensuring the sound financial condition of financial institutions is upheld.

The Superintendent has the powers, functions and duties which are assigned to the Superintendent under a number of Acts, including the *Insurance Companies Act*, as described above. Funding for the operations of the Office comes directly from the industries it supervises, by way of pro-rated assessments levied on the financial institutions for costs incurred in regulating the various sectors of the financial industry.

A recent legislative development has been the creation of the Financial Consumer Agency of Canada. The agency was established to strengthen the oversight of consumer issues and expand

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[1] *Insurance Companies Act*, *supra* note 22, ss. 165(2)(f),(g); ss. 479-489.2; ss 598-607.1.

[2] *Ibid.* ss. 676-692.

[3] S.C. 1987, c. 23.

consumer education in the financial sector. Similar to the Office of the Superintendent of Financial Institutions, this agency is funded entirely by the assessments on the financial institutions it regulates. The agency is headed by a Commissioner who is responsible for supervising financial institutions to determine compliance with the consumer provisions applicable to them and "promoting the adoption" of policies and procedures designed to implement these provisions.[4]

It is important to reiterate that the consumer provisions with respect to insurance companies over which the Commissioner exercises supervision, are those provisions of the *Insurance Companies Act*, mentioned above, which deal only with consumer issues surrounding disclosure of charges applicable to credit cards or the cost of borrowing.

The Commissioner also has power to monitor any voluntary code of conduct adopted by financial institutions designed to protect the interests of consumers and "that are publicly available."[5]

Provincial oversight

As discussed above, provincial authority over insurance is much broader than the federal authority. Their powers include:

- incorporating companies with "provincial objects"
- licensing insurers and overseeing the finances of provincially incorporated companies
- licensing and regulation of insurance agents and brokers
- authority over the contractual relationship between the insurer and the insured which includes matters of disclosure and misrepresentation and matters affecting the enforceability and content of insurance contracts[6]

Each province has a regulatory office or department to oversee the activities of insurance companies, which is established by legislation. In Ontario, the regulatory authority is the Superintendent of Financial Services, whose authority is established under the *Financial Services Commission of Ontario Act*.[7] This Act also establishes the Financial Services Commission of Ontario. Its purpose is to regulate

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[4]*Financial Consumer Agency of Canada Act*, S.C. 2001, c. 9.

[5]*Ibid.* s. 3.(2)(c). Presumably, this would mean that it has no supervisory power over the Guidelines under which member insurance companies operate, see *infra* note 42.

[6]Hayles, *supra* note 16 at 72.

[7]*Financial Services Commission of Ontario Act*, S.O. 1997, c. 28.

the financial institutions sector in Ontario, which includes those engaged in the insurance business and governed by the Ontario *Insurance Act.* The Superintendent's powers also include enforcing every Act that confers powers on the Superintendent, which, with respect to insurance, is the Ontario *Insurance Act.*

The provincial legislation contains provisions which give the Superintendent broad powers to regulate the contract of insurance and the relationship between the insurer and the insured.

Under section 51 (1) of the Ontario *Insurance Act*, the Superintendent is empowered to make a report if he or she "is of the opinion that there exists a state of affairs that is or may be prejudicial to the interests of persons who have contracts of insurance with an insurer licensed in Ontario." Following this report, the Superintendent is empowered to suspend or cancel an insurer's license.

There are also provisions dealing specifically with unfair or deceptive business practices. Such practices are defined in the regulations and include:

> 4. Any illustration, circular, memorandum or statement that misrepresents, or by omission is so incomplete that it misrepresents, terms, benefits or advantages of any policy or contract of insurance issued or to be issued.
>
> 5. Any false or misleading statement as to the terms, benefits or advantages or any contract or policy of insurance issued or to be issued.[8]

Under sections 438 and 441 of the Act, the Superintendent is empowered to investigate and report on such unfair or deceptive acts or practices and to make an order:

> (a) to cease or refrain from doing any act or pursuing any course of conduct identified by the Superintendent;
> (b) to cease engaging in the business of insurance or any aspect of the business of insurance specified by the Superintendent; or
> (c) to perform the acts that, in the opinion of the Superintendent, are necessary to remedy the situation.[9]

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[8]O. Reg. 7/00.

[9]*Insurance Act, supra* note 9.

Complaint reporting mechanisms

Federal

As indicated above, the Commissioner of the Financial Consumer Agency of Canada monitors financial institutions, including the insurance industry and can enforce the industry's compliance with the consumer provisions of federal legislation. However, the consumer complaint provisions of the applicable federal legislation governing insurance, the *Insurance Companies Act*, only deal with issues of complaints regarding disclosure of credit card charges and the cost of borrowing. The insurance contract itself or the relationship between the parties to the contract are elements outside federal jurisdiction.

Provincial

Provincial legislation varies with respect to procedures dealing with complaints. Ontario is one of the few provinces that has an insurance ombudsman. Under the Ontario *Insurance Act*, the Superintendent has the power to appoint the Insurance Ombudsman as an employee of the Financial Services Commission.

The Ontario Insurance Ombudsman is empowered to make enquiries into complaints about the business practices of insurers, to attempt to resolve such complaints and/or to make recommendations to the Superintendent to inquire into a complaint. The Ombudsman is self-described, however, as an "informal, last-step forum."[10] A person may submit a written complaint about an insurer's business practices to the Ombudsman if the person has already submitted a complaint to the insurer and the complaint has not been resolved within a reasonable period of time. The Ombudsman then gives the insurer the opportunity to respond to any complaint. After considering the complaint and the response, the Ombudsman may attempt to resolve the complaint or recommend that the Superintendent inquire into the complaint.[11]

The Insurance Ombudsman also offers this further qualification of its powers: "Our findings are non-binding on either party. You may want to consult a lawyer if you wish to pursue the matter further."[12]

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[10]Financial Services Commission of Ontario, "The Insurance Ombudsman: Working For You", (Ontario: Queen's Printer, 2000).

[11]*Insurance Act, supra* note 9, s. 5.1(3).

[12]Financial Services Commission of Ontario, *supra* note 43.

Recently the Financial Services Commission of Ontario established new standards for Ontario's consumer complaint handling system.[13] They include requirements to collect and submit consumer complaint data to the Office of the Insurance Ombudsman ("OIO") on a quarterly basis, commencing January 1, 2001, and the development of mechanisms to ensure that a complainant is informed of their right to have a complaint reviewed by the OIO.

The specific provisions of the guidelines suggest some major weaknesses with the new reporting standards related to how complaints are defined and how they are reported. The guidelines indicate that a "Reportable Complaint" is a complaint that has been "reviewed and dealt with at least one level "higher" than the level that routinely handles and makes operational decisions about the subject matter of the complaint."[14] Surprisingly, a reportable complaint *does not include* a customer complaint that is referred back to the front line operational level, following a customer's attempt to "escalate" the complaint to a "higher" level.[15]

It is difficult to understand the logical difference between a complaint that would be successfully "escalated" to a "higher" level and one that would be referred back to the front line operational level, since this is not explained. It also suggests two disturbing scenarios: 1) that customers attempting to complain about insurance practices may be sent into a complaint 'revolving door', where complaints may never reach a higher, or supervisory level within the insurance company and 2) that many complaints might never reach the OIO because they have not met this arbitrary definition of a "reportable complaint".

The complaint data reporting form (see Appendix "C") accompanying the guidelines is also deficient in not giving substantive information about the content of the complaints being dealt with by insurance companies. The form indicates nothing about the nature of the complaint received by the company (the functional categories include "claim" and "miscellaneous"). It is simply a numerical summary of complaints broken down by type of policy. It is unclear how this will meet one of the objectives of the guidelines which is to understand the nature of the complaints being dealt with by companies.

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[13]Financial Services Commission of Ontario, "Bulletin No. G-10/00 General" (November 7, 2000).

[14]Office of the Insurance Ombudsman, "Guidelines - Collection of Insurance Company Consumer Complaint Data", (November, 2000).

[15]*Ibid.*

Finally, companies will be *asked* to work with the OIO to develop mechanisms to ensure that a complainant is informed of his/her right to have complaint reviewed by the Ontario Insurance Ombudsman if it has not been resolved within a reasonable period of time. Presumably these protocols are being developed.

Insurance Industry Oversight

Despite the regulatory presence of the federal and provincial governments, the insurance industry is subject to self-regulation. The relationship between the insurance industry and the public and the business practices of the insurance industry are regulated by the industry itself. The CLHIA administers Guidelines[1] drawn up by CLHIA which govern its own activities and practices. The Guidelines govern:

- advertising of insurance products
- disclosure at the point of sale
- activities of insurance agents
- business practices of insurance companies

The CLHIA has also adopted a code of ethics which embody the principles behind the Guidelines.

It is important to observe initially, that the Guidelines are merely guidelines and not legally enforceable. They were originally developed by the provincial Superintendents of Insurance but were eventually superceded by Guidelines written by the CLHIA, in consultation with the insurance industry. It has been argued, however, that there is a strong incentive upon the insurance industry to comply with the Guidelines, in order to evade mandatory regulation imposed by government. Under self-regulation, however, there is limited ability for the public to evaluate this assertion, in the absence of any impartial third party to assess the industry's compliance with the Guidelines.

Examination of the Guidelines suggests that they do not impose very rigorous standards upon insurance companies. There are separate guidelines for life and for accident and sickness insurance and

[1]On March 20, 2002, I attempted, anonymously, to obtain a copy of the Guidelines by phoning the Consumer Assistance Centre of the CLHIA and the branch office of CLHIA in Ottawa. I was unsuccessful. The Consumer Assistance Centre agent told me that I would not be interested in reading the Guidelines because they are too long and was insistent upon knowing what specifically it was that I was concerned about. The Ottawa branch office told me that the Guidelines were for the member companies only, not the consumer. As a result, the substantive analysis of the Guidelines is based solely upon a secondary source, *Disability Insurance: Canadian Law and Practice, supra* note 16.

they apply only to individual insurance policies. The disclosure requirements for group insurance are set out in a separate guideline.

Guideline 39 governs practices around disclosure at the point of sale under accident and sickness policies. It states that a disclosure statement is to be delivered to the insured along with the policy. The Guideline also mandates a 10-day "free look"" period in which the insured is guaranteed an opportunity to review a summary of the policy terms and may rescind the contract before accepting the coverage unconditionally. The disclosure statement is to include a list of any third party payments, such as employment insurance, workers' compensation or Canada or Quebec Pension Plan which may result in a reduction of benefits under an integration of benefits clause in the policy.[2]

The Guidelines around disclosure under life insurance policies are much less demanding than under accident and sickness policies because they prescribe very limited disclosure. The Guidelines state that a company is required to give each applicant a written notice indicating that, at the applicant's *request*, he or she may receive a copy of the Association's "guide to buying life insurance" as well as a Policy Summary. The content of the disclosure is also very limited. The Guidelines focus on the financial aspects of the policy. There is no requirement for disclosure or explanation of the policy terms and exclusions.[3]

Industry complaint-reporting mechanisms

Analysis of consumer complaint-reporting mechanisms provided by the insurance industry and the nature of the complaints received, suggests that the complaint process is not transparent and that disability insurance complaints are a prominent feature.

The CLHIA operates a Consumer Assistance Centre, which receives consumer complaints about the insurance industry. Its complaint resolution process is not clearly set out in its literature, but seems to involve an initial step of referring a number of complaints directly back to the Presidents of the companies in question, for review and a response sent directly to the consumer.[4] The Centre's Annual Report for the year 2000 also reveals that disability insurance complaints were a predominant feature of complaints.(See Appendix "D")

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[2]Hayles, *supra* note 16 at 122.

[3]*Ibid.* at 121.

[4]Canadian Life and Health Insurance Inc., "Consumer Assistance Centre 2000 Annual Report", (CLHIA Inc.: Toronto, 2000) at 8.

A consumer complaint which comes to the Centre and is not resolved at the first level, either on the phone or in writing, (or which presumably comes back to the Centre despite being referred back to the company in question), has its final step in the complaints resolution process at the senior level of the Centre. A consumer who wishes to pursue a complaint which is not resolved at the senior level of the Consumer Assistance Centre, may ask the Ombudservice to pursue the matter on their behalf. The Ombudservice officer provides an informal conciliation process, mediating between the consumer and the company. In the year 2000, 17 of 138 complaints were referred to the Ombudservice. The majority of these complaints (65%) involved disability insurance products.[5]

The majority of complaints to the Centre in the year 2000 involved claims (48.9%), followed by complaints about insurance products (24.6%). Complaints about disability policies constituted the majority (50.9%) of complaints about the line of coverage.[6]

The Annual Report further analyzed the predominant reasons for complaints about disability insurance. Claims-related issues dominated the complaints about disability insurance (62.6%) and more than 53% of these involved the denial or discontinuation of benefits under a group disability policy. Product-related complaints about disability insurance constituted 30.1% of disability insurance complaints and centred on the definition of disability in the consumer's policy.[7]

A complaint-reporting mechanism about an industry and operated by that same industry, raises the inevitable concern about the capability of any organization to effectively police itself. A complaints procedure which includes referring complaints back to the industry, does not suggest an impartial method of dealing with complaints.

Conclusion

This cursory overview of public and private insurance as it relates to disability, raises a number of important questions about how these systems interact to affect the overall welfare of disabled insureds.

The analysis points to specific legislative provisions and industry practices which encourage and allow for integration of public and private disability benefits and the offsetting of those benefits. These

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[5] *Ibid.* at 11.

[6] *Ibid.* at 9.

[7] *Ibid.* at 10.

factors have also fundamentally altered the conception of the disability insurance contract to the detriment of the disabled insured. They have strictly limited the level of benefits available to the disabled and have burdened claimants with procedural obligations and financial burdens.

This analysis also suggests that legislative oversight mechanisms do exist, mostly at the provincial level, but do not appear to be well-utilized. At the same time, the mechanisms of self-regulation applied by the industry are not legally binding nor are they transparent to the public.

At the same time, the common law has affirmed that the nature of the insurance contract and particularly a disability insurance contract, takes it out of the realm of ordinary contract law principles. It imports higher standards of utmost good faith and honesty on both of the parties. It also affirms that "peace of mind" or relief from mental stress is specifically contracted for when an insured enters into an insurance contract. The current practices around disability insurance do not suggest that either of these principles is being upheld.

APPENDIX "A"

GIDIP BOOKLET

This Plan is administered by
CANADIAN BENEFITS CONSULTING GROUP LTD.

with Short Term Disability claims paid by
CANADIAN BENEFITS at

2300 Yonge Street, Suite 3000
Toronto, Ontario
M4P IE4

Telephone: (416) 488-7755
Toll Free: 1-800-268-0285
Fax: (416) 488-7774

and is underwritten by
THE GREAT-WEST LIFE ASSURANCE COMPANY
(formerly The London Life Insurance Company)

Long Term Disability Claims are paid by Great-West Life

IMPORTANT

This booklet has been prepared to help you better understand your Group Insurance Disability Income Plan (GIDIP). However, it does not take the place of any contractual or other rights. In the event of discrepancy between any information contained in this booklet and the Group Policy, the terms of the Group Policy will apply.

next ..>

CAW TCA
CANADA
LOCAL 2213

CAW TCA CANADA

HIGHLIGHTS

Eligibility:

You must meet the criteria of *Total Disability* and be unable to work for *14 consecutive calendar days.* Benefits become eligible on the 15th consecutive day you are certified Totally disabled with Medical Support satisfactory to Great-West Life.

Under The Short Tern Disability Contract:

Total Disability means that because of accidental bodily injury or sickness you are not able to perform *any and every duty* pertaining to your own job; AND you are not working at any job for wage or profit.

Eligible Short Term Disability Benefits are paid every 2 weeks, in arrears.

Under Employment Insurance (EI):

Employment Insurance (EI) is a government-sponsored program. If it appears that your Total Disability may continue into the Employment Insurance period of the disability claim, Canadian Benefits will provide the necessary forms for you to apply to EI for benefits.

Under The Long Term Disability Contract:

In the *FIRST 24 MONTHS* you receive Long Term Disability (LTD) benefits, *Total Disability* means that because of accidental bodily injury or sickness you are not able to perform *any and every duty* pertaining to your own job; *AND* you are not working at any job for wage or profit; *AND*, you are not confined in a penal institution or other house of correction as a result of conviction for a criminal or other public offence.

The definition of *TOTAL DISABILITY* changes after you have received LTD benefits for a period of ***twenty-four consecutive months***: thereafter you must be TOTALLY DISABLED from performing *any and every gainful occupation* for which you are reasonably fitted by education, training or experience: *AND* not working at any job for wage or profit (other then Rehabilitative employment approved by Great-West Life); *AND* you are not confined in a penal institution or other house of correction as a result of conviction for a criminal or other public offence.

Eligible Long Term Disability Benefits are paid monthly, in arrears.

Canada Pension Plan / Quebec Pension Plan:

You *must* apply for Canada Pension Plan (CPP) or Quebec Pension Plan (QPP) Sick benefits if so requested by Great-West Life. If you became disabled prior to June 1, 1996, 100% of any amounts awarded to you (*excluding* CPP/QPP monies received for your dependent children) *reduce* your GIDIP benefits in that amount.

For Members who became disabled after June 1, 1996 a 90% CPP/QPP offset has been negotiated with the insurance carrier to allow for the fact that while GIDIP payments are non-taxable, CPP/QPP benefits are

taxable.

Application Forms for the Canada Pension Plan or Quebec Pension Plan (**CPP/QPP**) sick benefits are retained in our Plan Administrators office and mailed to Members, when applicable.

If such benefits are denied to you, you must, at the request of Great-West Life, appeal this decision. ***Please note that receiving CPP/QPP benefits if you become totally and permanently disabled has a positive affect on your CPP/QPP retirement benefits.***

Receiving Benefits:

In order to meet the requirements of the *Total Disability* definition you must be under the regular, active, supervised care of a Physician who is qualified to treat your Disability. As well, *you* must be following the course of treatment prescribed by the physician and which reflects recognized, standard medicine practice relative to the cause and nature of the Totally Disabling condition. If these conditions are not met and objective **medical** information is not submitted to support your claim, GIDIP benefits will not be paid.

At all times -- it is the responsibility of the Member to fulfill the terms of his/her GIDIP claim.

Medical Support:

In order to meet the needs of our Members, our Plan Administrator has retained the Services of an in-house Medical Consultant. Canadian Benefits' Medical Consultant provides various assistance to their staff in order to better service you, the Member. For example, in some instances, the Plan Administrator's Consultant can simply pick up the phone and contact your Physician directly to clarify a concern that has arisen in your claim. This limits, at times, the need for lengthy correspondence back and forth and can shorten the claim decision period on your new or ongoing GIDIP claim.

Substance Usage:

Your Plan specifically states where alcohol, drug or other substance use disorder is involved, benefits will not be eligible unless a Member is either:

1. confined in a hospital or other institution qualified to provide care and treatment for alcoholism or drug addiction and is under the continuous care of a Physician, or
2. is undergoing regular rehabilitative treatment supervised by a Physician and approved in writing by Great-West Life.

Modified Return To Work Program:

Both your Short Term and Long Term Disability Plans provide a Modified Return To Work Program for Members who are unable to return to their previous job on a full-time basis immediately after receiving GIDIP benefits under these Plans. A Modified Return To Work Program may be available to assist you in returning to your job on a fulltime basis up to the level of your pre-disability employment with the company.

If you feel you would he a candidate for such a Program while receiving GIDIP benefits, please discuss this with your disability adjudicator and contact your local Chairperson/Trustee to confirm the availability of Modified Return To Work. at your location. Alternatively, Canadian Benefits, Great-West Life, or its Representative may contact you to discuss the restrictions and or modifications pertaining to your job and schedule; the "whys", "hows" and "wheres" of a Modified Return To Work Program as well as answer any and all questions you may have relating to this Program. Physician awareness includes writing or calling your Doctor. To receive partial benefits during a return to work on a Rehabilitation schedule under your

Plan, the Insurance Company must approve the Program. Once a Modified Return To Work Program is approved by Great-West Life, you will receive benefits for the time period you are unable to work by submitting the hours you worked to the Plan Administrator. GIDIP benefits will be calculated based on the percent of the schedule you are working; for example, if you are working 60% of your regular schedule, GIDIP will pay 40% of your regular benefit.

Contributions (premiums) are waived when you are on an Insurance approved Modified Return To Work Program, however, if contributions are deducted from your wages, please refer to page 17 or 25 in reference to reimbursement.

Taxability:

Because you pay the premiums for your Disability Plan, any benefits you receive from the Plan are *non-taxable* and you will *not* receive a T4A statement.

Your CPP/QPP benefits however, are *taxable* income for you and are your responsibility. **CPP/QPP benefits (*exclusive* of any dependent benefits) are used to offset your GIDIP benefits. If you became totally disabled after June 1, 1996 only 90% of your CPP/QPP benefit is used to offset your GIDIP benefits.**

Workers Compensation (WC) Claims:

Where Disabilities are the result of work **accidents or illnesses,** GIDIP requires that you file a Workers' Compensation (WC) claim. You must also file a WC claim where it is identified that work related stress has resulted in Total Disability. Your Union Health & Safety Representative can help you do this. If WC declines your claim, you will usually be expected to file an appeal of that decision.

Under the GIDIP, disabilities arising out of a work related illness or injury cannot be considered for benefit without confirmation that a WC claim has been filed, because WC is the first payer. GIDIP provides BRIDGE-FINANCING, if your WC claim is pending, as long as you promise to repay the plan if you recover any WC Benefits in the future, for the same time period, and to Appeal the WC decision when directed to do so by the Insurance Company.

Bridge-Financing If you have filed a WC claim and need financial help while you wait for WC Board's decision, GIDIP can provide you with financial assistance when your medical information supports Total Disability.. Essentially this means that GIDIP will advance you eligible benefit money while you are awaiting and/or appealing the WC decision. To be eligible for bridge-financing you must:

- have submitted a GIDIP claim form to Canadian Benefits within 90 days of the original date of your disability, and
- provide medical proof that you are Totally Disabled, and
- complete and sign: **a)** an assignment form which allows GIDIP to recover the money you were advanced if WC accepts your claim, **b)** a form allowing WC to release information on your file to the Plan Administrator or the Insurance Company and **c)** a Reimbursement Agreement, promising to repay GIDIP any money you were advanced if your WC Claim is accepted.

If WC declines your claim, you will be required to provide a copy of their letter along with a copy of the appeal request (where applicable) to the GIDIP. If you have been on WC and your claim has been terminated, but you are unable to return to work, a release form allowing WC to release medical information to GIDIP must be on file. Without this signed release GIDIP will be unable to consider your claim.

Third Party claim (Subrogation):

If you are in a motor vehicle accident or other accident/incident where you have the right to recover compensation for loss of income which caused or contributed to your Total Disability and for which benefits were paid under GIDIP, Great-West Life will have the right to recover the amount of benefits paid to you during this period. These monies will be put back into your Plan.

This means that you are awarded compensation from a Third Party, the monies paid to you in benefits under GIDIP must be returned to the Plan with payment being made to the insuring company, Great-West Life. Your repayment to the Plan is not dependent upon specific settlement made for wage replacement. This means that if you have accepted any type of settlement, it is recognized as an all-inclusive settlement, including wage replacement, and monies advanced to you must be repaid to the Plan.

Always communicate directly with our Plan Administrator if you have any claims related concerns or questions. Canadian Benefits' address and telephone directory is located on the opening page of this GIDIP booklet. Their staff will always take the time to listen to you and offer assistance, based on your needs, in a professional and caring manner. Alternately, claim appeals or member concerns may be directed to your regional Trustee.

Board of Trustees
CAW Local 2213
Health and Welfare Trust Fund
Group Policy No. 328802

back next

Return to table of contents / Booklet home page

Group Insurance Disability Income Plan (GIDIP) © 2000

The
Great-West Life
ASSURANCE COMPANY

January , [illegible]

Dear

Re:
Group Plan Number
Employee ID Number

We have received a copy of the declination letter from Canada Pension Plan.

Since medical information received supports your inability to work, it should also satisfy Canada Pension Plan's definition of total disability. We recommend that you appeal their decision.

Instructions for appealing this decision are included in their letter. Please advise us by telephone or letter if you would like Great-West Life to send the medical information on file directly to Canada Pension Plan to assist with your appeal.

If we do not hear from you within three months regarding the status of your appeal, we will estimate the Canada Pension Plan disability benefits you may be eligible to receive and deduct them from your current disability benefits.

If you have any questions, please call me at or toll free at

Sincerely,

Disability Claims Specialist

Sun Life
Group Disability Management

April 2010

Dear Mr

RE: **Name of Claimant:**
Contract Number:
Control Number:

Your letter has been referred to me for reply and I have reviewed Mr claim file as well as the policy provisions.

It is our position that Mr has a duty to mitigate his losses by making all reasonable efforts to apply for and obtain CPP disability benefits. In this regard, we assert that any expenses incurred to establish eligibility for CPP benefits are his responsibility.

Furthermore, we disagree with your assertion that the benefit of a favourable decision from the Review Tribunal would accrue only to and not to Mr Under the provision of the policy Sun Life will only deduct the amount of the initial award from its monthly benefit cheques. As such Sun Life does not adjust its benefit to include the annual increases in the CPP disability benefit. Mr would therefore be entitled to the entire increase in benefit.

The amount of Mr CPP retirement pension is calculated based on his contributions to the plan while working. Should Mr not pursue his application for disability benefits with CPP the amount of his pension will be adversely affected by the fact that he will not have contributed to the fund for several years. It is our understanding that this penalty is greatly reduced if he is in receipt of CPP disability benefits.

That being said, although Dr report was not included with your letter, we recognize that Mr health may make it difficult for him to attend the hearing. As such, we are willing to consider funding a portion of his legal fees. Although you have provided Sun Life with confirmation of your rating schedule, we would appreciate receiving an estimate of the hours and costs expended on this case.

I will provide you with a final decision as soon as we have received the above information.

Yours truly,

CLARICA

Canada Pension Plan ("CPP") Agreement

Name: Policy: Certificate:

You are responsible under your plan to apply for CPP benefits and to keep Clarica Life Insurance Company ("Clarica") informed of your application as well as any decision. Please read this Agreement carefully, sign it, and return it to us at the following address:

I understand the Plan requires me to apply for disability benefits payable under CPP and that any CPP benefits that I am entitled to receive, reduce directly any long term disability ("LTD") payable to me under the Plan. I also understand that this reduction applies both to LTD benefits I received before my CPP entitlement was determined, as well as to LTD benefits payable after.

Therefore, in consideration of paying unreduced LTD benefits for any period during which I may be entitled to CPP benefits I agree to the following terms:

1. I will apply for CPP benefits and will immediately notify [illegible] of the CPP decision.
2. I will provide **Clarica** with any CPP correspondence received from the CPP office.
3. If my application is denied, **I will appeal the denial within** [illegible] days of being so directed by **Clarica** to do so.
4. I will sign the enclosed assignment form from the CPP Office "[illegible] Payment of Canada Pension Plan Disability Benefits to an Administrator of a Disability Income Program", and return it to **Clarica** along with this Agreement form.
5. I agree that within **10 days** from the date I receive payment from CPP, I will reimburse **Clarica** in a lump sum, for all payments it has advanced to me related to CPP which have not been reimbursed directly to **Clarica** by CPP.
6. If I do not comply with any of the terms in this Agreement, I agree that **Clarica** has the right to withhold or reduce my **LTD** benefits, until the amount of CPP disability benefits to which I may be entitled has been exhausted.

This agreement shall bind my heirs, executors, administrators and assigns.

☐ I confirm that I applied for CPP disability benefits on ______________ at ______________

OR

☐ I confirm that I appealed the denial decision of ______________ on ______________

______________________ Date ______________
Signature

______________________ Date ______________
Witness

NOTE: If this agreement is not returned to Clarica within 2 months of being requested, your LTD benefit payments may be reduced by an estimate of the amount of benefits to which you may be entitled under the Canada Pension Plan

CLARICA

DISABILITY BENEFITS STATEMENT

NOV [illegible]

PAGE [illegible]

POLICY #
SECTION
CERT.

([illegible]) Although your original claim for Canada Pension Plan (CPP) benefits was declined, please appeal the CPP decision as soon as possible so that adequate time is given to CPP to reassess your claim. Please sign the enclosed (CPP) Agreement forms and return one copy within two months from the date of this notice. The Agreement should reflect the date of your appeal. The second copy of the Agreement is for you. Failure to do so will result in your future benefits being reduced by our estimate of the amount deemed payable by CPP. Any expenses incurred as a result of your appeal are your responsibility.

You should write "I wish to appeal this decision" on your letter of denial from CPP and include the date, your social insurance number and signature. Please return the form to Human Resources Development Canada, Disability and Reconsideration Division. The address is on the letter of denial. Please send a copy of your appeal request to your Clarica Disability Claims Analyst. QPP applicants should contact the local branch of the Regie des Rentes du Quebec for an appeal form. Please complete the form and return it to the local office, and send a copy of your appeal request to your Clarica Disability Claims Analyst.

Once approved for CPP disability benefits, please send a copy of your "Notice of Entitlement" to us. We will calculate any overpayment you have received. You must repay this amount by the due date, which will be specified by letter, or your disability benefits will be suspended until full repayment has been made. For Quebec residents, Clarica will calculate any overpayment you have received and notify you. Repayment guidelines are the same as for CPP disability benefits.

Great-West Life

November [illegible]

Dear Mr

RE: [illegible]

Group Plan Number
Employee ID Number

Thank you for notifying us of your declination from Canada Pension Plan for disability benefits.

Since medical information received supports your inability to work, we believe that it should also satisfy Canada Pension Plan's definition of total disability. We recommend that you appeal their decision.

Instructions for appealing this decision are included in their letter. Please advise us by telephone or letter if you would like Great-West Life to send the medical information on file directly to Canada Pension Plan to assist with your appeal.

If we do not hear from you within three months regarding the status of your appeal, we will estimate the Canada Pension Plan disability benefits you may be eligible to receive and deduct them from your current disability benefits.

If you have any questions, please call

Sincerely,

Disability Claims Specialist

Sun Life

August [illegible]

[illegible]

Under the terms of the Disability Insurance Group Contract, it is the claimant's obligation to pursue CPP benefits and our obligation to follow up with this process and if CPP benefits are not actively pursued, we are then obliged to deduct an estimate from the monthly Long Term Disability benefits. Therefore, since CPP is considered first payors, please file an appeal as soon as possible. Please forward any correspondence that you may have from CPP in regards to your Disability benefit application to our offices by [illegible]. Yours sincerely,

Disability Claims Administrator

cc [illegible]
[illegible]

September 23,1999.

Director,
Appeals and Reconsideration,
Disability Benefits,
Canada Pension Plan,
Human Resources Development Canada
P.O. Box 2710 Main Station,
Edmonton, Alta. T5J 4C2

Dear Sir or Madam;

Re: CPP Disability Benefits

My application for Canada Pension Plan disability benefits dated January,99 was reviewed and denied.I talked this decision over with my physician who deals with CPP disability benefits on a daily basis as a consultant with the W.C.B. and he advised my not to appeal your decision. I informed the company carrying my LTD-Sun Life- of your decision and my reason not to appeal. Please note the attached letter from Sun Life suggesting I file an appeal -that is the reason I am requesting an appeal.

Thank you for your consideration of the above and I am sorry to have to waste your valuable time on such.

Yours Truly,

Sun Life

September [illegible]

Re: Contract No.: Sub. No.:
Employee I.D.: Control No.:

We have received your recent letter with regard to your Long Term Disability claim and CPP appeal status.

Under the terms of the Disability Insurance Group Contract, it is the claimant's obligation to pursue CPP benefits and our obligation is to follow up with this process and if CPP benefits are not actively pursued, we are then obliged to deduct an estimate from the monthly Long Term Disability benefits. Therefore, since CPP is considered first payors, we strongly suggest that you file an appeal as soon as possible.

If we can be of any assistance or if you have any questions, please feel free to contact our office.

Yours truly,

LTD Adjudicator

Ontario Teachers Insurance Plan
Long Term Disability Insurance
Claims Services Unit

January [illegible], 200[illegible]

Subject: Long Term Disability

Dear [illegible]

Thank you for sending us a copy of the declination letter from the Canada Pension Plan.

Since medical information received supports your inability to work, we believe that it should also satisfy Canada Pension Plan's definition of total disability. We recommend that you appeal their decision.

Instructions for appealing this decision are included in the CPP denial letter. Please call me if you require any assistance in appealing the Canada Pension Plan decision. At your request, OTIP/RAEO will send the medical information on file directly to Canada Pension Plan to assist with your appeal.

Please keep us informed of any progress with your appeal. If we do not hear from you within three months regarding the status of your appeal, we will estimate the Canada Pension Plan disability benefits you may be eligible to receive and deduct them from your current disability benefits.

If you have any questions or concerns, please do not hesitate to contact me at (519) 88[illegible]-9683 or 1-800-[illegible], ext. [illegible].

Sincerely,

Disability Benefits Assistant

The Mutual Group

October [illegible] 199[illegible]

CANADA PENSION PLAN ("CPP") AGREEMENT

Name: [illegible] F. [illegible] C

[illegible] plan to apply for CPP benefits and to keep The Mutual Life Assurance Company of Canada ("Mutual") informed of your application as well as any [illegible]. Please read this Agreement carefully, sign it, and return it to us at the following address.

I understand that the Plan requires me to apply for disability benefits payable under CPP and that any CPP benefits that I am entitled to receive reduce directly any long term disability ("LTD") payable to me under the Plan. I also understand that this reduction applies both to LTD benefits I received before my CPP entitlement was determined, as well as to LTD benefits payable after.

Therefore, in consideration of paying unreduced LTD benefits for any period during which I may be entitled to CPP benefits I agree to the following terms:

1. I will apply for CPP benefits and will immediately notify Mutual of the CPP decision.
2. I will provide Mutual with any CPP correspondence received from the CPP office.
3. If my application is denied, I will appeal the denial within [illegible] days of being requested by Mutual to do so.
4. I will sign the enclosed assignment form from the CPP Office "[illegible] and Payment of Canada Pension Plan Disability benefits to an Administrator of a Disability Income Program", and return it to Mutual along with this Agreement form.
5. I agree that within [illegible] days from the date I receive payment from CPP, I will reimburse Mutual in a lump sum, for all payments it has advanced to me related to CPP which have not been reimbursed directly to Mutual by CPP.
6. If I do not comply with any of the terms of this Agreement, I agree that Mutual has the right to withhold or reduce any LTD benefits, until the amount of CPP disability benefits to which I may be entitled has been [illegible].

This agreement shall bind my heirs, executors, administrators and assigns.

☐ I confirm that I applied for CPP disability benefits on

________ XX________ at ________

OR

☐ I confirm that I appealed the decline decision on

XX ________ at ________

________________ ________________

Signature Date

________________ ________________

Witness Date

NOTE: If this agreement is not returned to Mutual Life of Canada within 2 months of being requested, your LTD benefit payments may be reduced by an estimate of the amount of benefits to which you may be entitled under the Canada Pension Plan.

Great-West Life

Assurance Company

November [illegible]

Dear

RE:

Group Plan Number
Employee ID Number
London District Catholic School Board

This is in reference to your Long Term Disability benefit.

We have received partial reimbursement from the Workplace Safety & Insurance Board for the acceptance of your claim for the period Great-West Life paid benefits to you.

Therefore, we have recalculated your monthly benefit effective which was the date you first received payment from Great-West Life for your Long Term Disability benefits.

Under the provisions of your group plan, your monthly maximum benefit amount is $1,500.00. Since you are in receipt of WSIB benefits in the amount of $1,555.42, all monies paid to you from Great-West Life while you were in receipt of WSIB benefits must be recovered.

For the period we have paid you $13,086.56. We have deducted $3,581.44 (estimating your Canada Pension Plan disability benefits which you are currently not in receipt of), which leaves an overpayment balance in the amount of $9,505.12. WSIB has reimbursed us in the amount of $4,451.04. Unfortunately, an outstanding balance of $5,054.08 remains outstanding.

Please send a cheque payable to Great-West Life Assurance Company in the amount of $5,054.08 as soon as possible.

Your current monthly Long Term Disability benefit is as follows:

LTD	$1,500.00
Less WSIB	$1,555.49
Net Benefit Payable	0.00

Your immediate attention in this matter will be appreciated. Thank you for your anticipated cooperation.

Should you have any questions regarding this matter, please contact me at 1-[illegible] [illegible].

Sincerely,

Disability Claims Specialist

APPENDIX "B"

Great-West Life

August 4, 1992

Dear

RE: Group Policy Number

This is in reference to your Long Term Disability claim.

Under the provisions of this group plan, Long Term Disability benefits commence following a waiting period of 24 weeks. During this waiting period and the next 24 months, you are considered disabled if disease or injury prevents you from performing the duties you regularly performed for the employer before disability started. After this initial assessment period of 24 months, you are considered disabled if disease or injury prevents you from performing the regular duties of any occupation for which you have at least the minimum qualifications.

At the present time, based on the medical information on file, you are considered unable to perform the duties of your regular job. We would like to point out, however, that your claim remains under review, and we will require updated medical documentation throughout the duration of your claim for our ongoing assessment of your continued entitlement to benefits. You will be notified should there be any change regarding the status of your claim.

The waiting period commenced on July 3, 1991 and was satisfied July 2, 1992. Your Long Term Disability benefit cheque will cover the monthly period from the 3rd of the previous month to the 2nd of the month of issue. Your first cheque covering the period July 3, 1992 to August 2, 1992 inclusive has now been released. This cheque is in the amount of $0.00 as you are still in receipt of sick leave benefits. Subsequent cheques will be issued on approximately the 22nd day of each month.

The gross benefit for which you are insured is 60% of your pre-disability monthly earnings. Your gross monthly benefit is $1163.00. Benefits will continue at this amount provided there is no other reportable income, as outlined in the transcript of the interview mailed to you for signature. Other income is either directly reduced from the gross Long Term Disability benefit or it is co-ordinated with your Long Term Disability benefit.

APPENDIX "C"

Company Complaint Data Reporting Form

Company Name: _____

Contact Name: _____ Phone number: _____

Ombudsman Liason Officer: _____

Fax Number: _____ E-mail Address: _____

Reporting Period: 1st Quarter / 2nd Quarter / 3rd Quarter/ 4th Quarter Year _____
(circle Quarter)

Please complete the following breakdown of complaints received during the period -

	Function							
	Under-writing &Rating	Marketing & Sales	Sales Intermed-iaries	Claims	Policy - Owners Services	Product	Micell-aneous	Total
Line of Business								
Automobile								
Property & Liability								
Accident & Sickness/ Disability/Health								
Individual								
Group								
Creditor								
Total A&S								
Travel								
Individual								
Group								
Creditor								
Total Travel								
Life								
Individual								
Group								
Creditor								
Total Life								
Investments Annuities/Variable Insurance Contracts								
Total Complaints								

Information submitted in confidence to the Financial Services Commission of Ontario's Office of the Insurance Ombusman

APPENDIX "D"

Consumer Assistance Centre

2000 ANNUAL REPORT

Canadian Life and Health Insurance Association Inc.

Association canadienne des compagnies d'assurances de personnes inc.

TORONTO / MONTREAL / OTTAWA

1 Queen Street East
Suite 1700
Toronto, Ontario
M5C 2X9

Tel: [416] 777-2221
Fax: [416] 777-1895
www.clhia.ca

1, Rue Queen Est
Bureau 1700
Toronto (Ontario)
M5C 2X9

Tel.: [416] 777-2221
Fax: [416] 777-1895
www.accap.ca

Canadian Life and Health Insurance Association Inc.

Association canadienne des compagnies d'assurances de personnes inc.

Consumer Assistance Centre
2000 ANNUAL REPORT

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Consumer Assistance Centre Profile

What is the Consumer Assistance Centre (CAC)?

The life and health insurance industry's Consumer Assistance Centre is a national consumer help service available in both English and French. It operates out of the Canadian Life and Health Insurance Association Inc. (CLHIA) offices in Toronto and Montreal, and is accessed by consumers through toll-free telephone lines which account for most contacts; electronic mail, now the source of most written requests for information and assistance; traditional mail; faxes; and in person.

Since its inception in 1973, the CAC has handled more than 900,000 calls, providing assistance to Canadians of all ages, from all walks of life, from all across the country.

Consumers are by far the predominant source of calls (more than 90 per cent). But agents, brokers and insurance companies also use the CAC as a central source of timely and accurate industry information.

What services are provided?

The CAC handles an average of nearly 62,000 calls per year, most of them from policyholders and other consumers.

Callers request:

- **information** about life and health insurance products and services, company addresses and phone numbers;
- copies of **publications** on life and health insurance products and services and financial/retirement planning;
- **policy search assistance,** or help locating life insurance policies that may have been misplaced;
- **information about CompCorp,** the organization that runs the industry's consumer protection plan;
- information about how **Holocaust victims and heirs** can search for lost insurance proceeds (special service); and
- in a very small number of cases, **assistance in pursuing complaints.**

Who responds to the calls?

The CAC is staffed by counsellors with extensive industry backgrounds. Most are retired insurance company executives with in-depth expertise in many aspects of the industry, including claims, law and marketing.

These counsellors bring knowledge, patience and empathy to the task and draw upon the collective industry experience of the group to provide accurate, objective information to callers. When required, they can also call on the expertise of the numerous industry specialists at the CLHIA.

Consumer concerns or complaints

In a very small number of cases a caller raises a concern or complaint about some aspect of his or her relationship with a life and health insurance company. Such problems are often resolved during the first telephone contact, when counsellors provide background information on industry practices and guidelines and common operational procedures.

If the consumer wishes to pursue a complaint further, the CAC will bring the matter to the attention of the company President, in writing.

OmbudService

In keeping with the industry's commitment to meeting the needs of life and health insurance customers, an OmbudService was introduced in 1998 to enable consumers to pursue further outstanding concerns and complaints. This service provides consumers with access to an additional conciliation process and significantly strengthens the industry's ability to respond effectively to their problems, adding value to the CAC's complaint resolution capacity.

Holocaust support service

This dedicated toll-free telephone service, also established in 1998, helps locate unclaimed insurance proceeds that may be owed to victims and survivors of the Holocaust and their heirs.

Activity Highlights

Number of enquiries

In 2000, more than 56,000 people called the CAC, seeking information and assistance on almost 72,000 different topics. More than 90 per cent of the calls came from individual consumers.

Reasons for calls

More than half the calls involved requests for product information. Another 30 per cent were from consumers seeking information about life and health insurance companies. Together, these two categories accounted for more than 80 per cent of calls received by the CAC.

Almost 70 per cent of the product information enquiries concerned health insurance, whether travel/visitors to Canada or extended health and dental insurance.

Consumer publications

In 2000, the CAC distributed almost 20,000 consumer publications from the list of a dozen titles produced and kept up to date by the CLHIA and CompCorp. The most popular publications have to do with life, disability and travel insurance.

Policy searches

More than 1,800 people called during the year for help locating possible life insurance policies on deceased persons, or for advice on how to locate possible misplaced policies of their own. Policy searches were carried out in 117 cases, with a positive "find" ratio of 14 per cent.

Concerns or complaints

Of the 72,000 enquiries, a little more than 1000, or less than 1.5 per cent, involved concerns or complaints. CAC counsellors resolved or dealt with 572 at the initial point of contact.

A further 432 complaints moved forward to written status. By year end, the CAC had made an initial response to 258 of these. The remaining 174 had been referred to the Presidents of the companies in question for response.

OmbudService

In 2000, 17 consumers expressed interest in pursuing their complaints through the OmbudService, after completing the initial complaint resolution process. This brings to 44 the number of consumers who have sought the service's help since it was established in the fall of 1998. Of the 28 cases processed by the service (five are awaiting consumer authorization before proceeding and 11 policyholders eventually elected not to use the service), 26 files have been closed. Of these, the insurer's position was revised in favour of the consumer in six cases, or 23 per cent.

Advisory Board

In April 2000, the CLHIA enhanced the industry's CAC through the establishment of a seven-person Advisory Board with a view to maximizing the CAC's usefulness to consumers.

Volume of enquiries

In 2000, the CAC responded to 56,090 calls, down slightly from the previous year, as shown in Chart i. These calls involved almost 72,000 enquiries on individual topics.

Who called us?

The CAC's clientele consists first and foremost of consumers, who consistently make up more than 90 per cent of all callers, and in 2000 accounted for fully 93 per cent. Calls from agents, involving product enquiries, policy searches and company information, have averaged almost 6 per cent of total calls during the last three years. Enquiries from insurance companies, concerning industry guidelines and regulations and company information, typically represent a little more than 2 per cent of all calls.

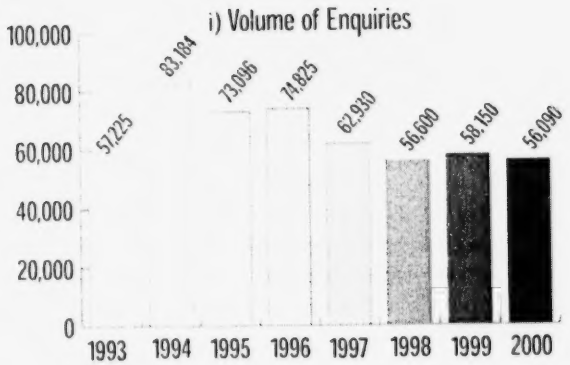
How did they hear of us?

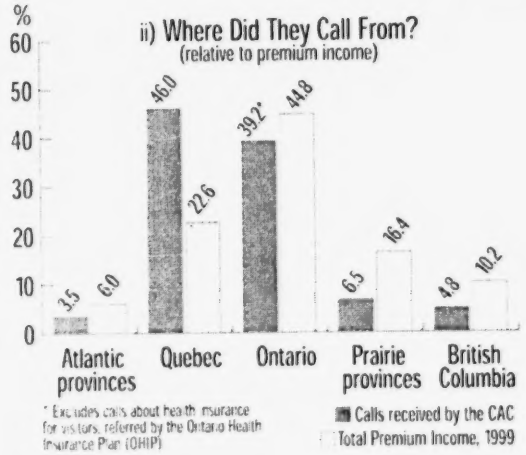
Callers learn of the CAC through a variety of sources, including agents, newspaper articles, government and constituency offices, insurance companies and other related trade and industry associations. Approximately one third of callers learn of the service through advertising in the regular white and yellow pages, and the electronic yellow pages of phone books, in 196 communities across Canada.

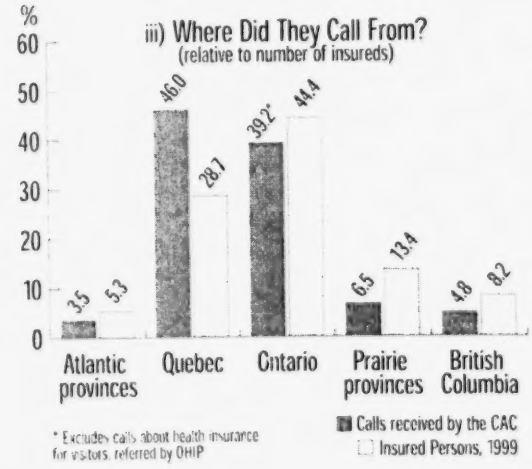
Where did they call from?

In general, the volume of calls tends to follow both the distribution of premium income and percentage of insureds across Canada. That more calls come from Quebec than any other province or region is mainly due to the fact that many Quebec government agencies routinely refer callers to the CAC. Chart ii shows the percentage of contacts from each region alongside the percentage of total premium income from the same region, based on 1999 statistics.

When the regional distribution of calls is compared to the percentage of persons insured under life and health insurance policies, as in Chart iii, the gap tends to narrow somewhat in all regions.





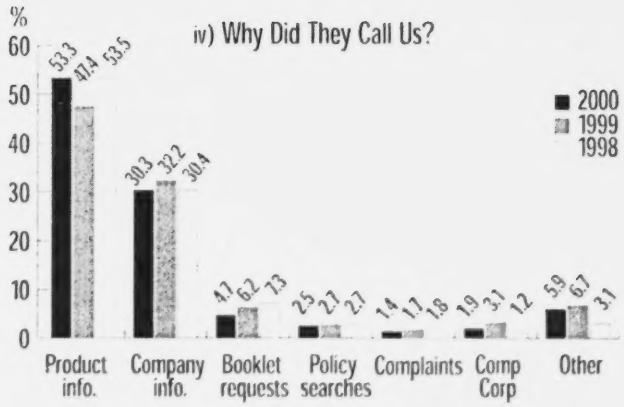


Why did they call us?

In the course of 56,090 calls to the CAC last year, 71,889 individual topics were addressed, which is to say that callers often raised more than one topic.

Chart iv shows that more than 53 per cent of the topics raised related to requests for generic information about life and health insurance products, including policy provisions and exclusions, along with questions about distribution.

The following analysis, which provides additional detail about callers' reasons for contacting the CAC, is also based on the number of topics raised.



Product information

Almost 70 per cent of the product information enquiries concerned health insurance, whether related to travel and/or visitor to Canada or extended health care and dental insurance.

The year-over-year increase in the volume of travel health enquiries, as shown in Chart v, is due to changes in policy provisions and increased rates in a number of individual travel plans in 2000, primarily as the result of rising health care costs in the U.S.

The gradual increase in enquiries involving disability insurance parallels a similar rise in the volume of claims for these products, as noted in *Canadian Life and Health Insurance Facts,* the industry statistical publication.

Although travel and extended health insurance are sold on both an individual and group basis, it is estimated that 95 per cent of enquiries to the CAC are from consumers who are interested in purchasing such coverage on an individual basis, and require general information about providers, underwriting and policy provisions.

Company information

Chart vi shows that nearly 88 per cent of company information enquiries involved requests for telephone numbers and addresses and other queries of a general nature. Many of these requests were due to consumers' need for clarification as a result of industry merger and acquisition activity. Product information requests, at almost 9 per cent, involved queries about various products offered by specific companies, as opposed to generic product enquiries, which are dealt with above under "Product information."

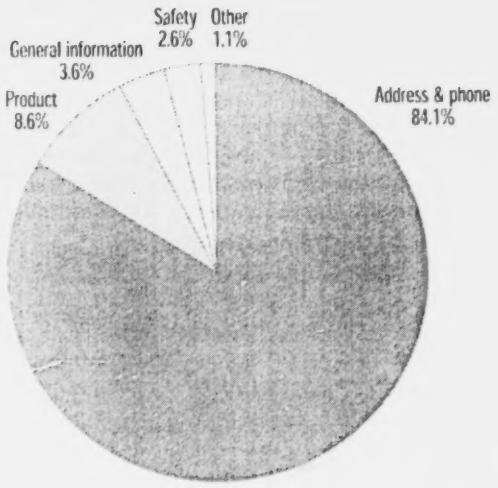
Booklet requests

The CLHIA produces a variety of consumer publications providing information, guidance and tips on the range of insurance company products and services available. The cost of production is borne by the industry. Single orders are free; a small fee is charged for bulk orders, to cover shipping charges.

The CAC distributed some 20,000 booklets in 2000, down about 8 per cent from the previous year. Requests for CompCorp booklets were for the most part bulk orders received from insurance companies and brokerages, while requests for CLHIA publications usually involved single copy orders from consumers.

The CompCorp booklet accounted for more than 50 per cent of the publications distributed in 2000. Booklets on life and disability insurance accounted for about 21 per cent; travel health insurance, about 8 per cent; retirement planning, 2 per cent; and other publications, about 18 per cent.

vi) Company Information



Consumer publications include:

Life	A Guide to Buying Life Insurance
Health	A Guide To Health Insurance (new in the summer of 2001) Disability Insurance: Where Will the Money Come from if You're Disabled? Health Insurance for Travellers: What you should know before leaving Canada
Retirement Planning	Retirement: As You'd Like It Consumer Tips: RRSPs with Life Insurance Companies
Financial Planning	Consumer Tips: Segregated Funds The Shoe Box Guide – Personal and Family Documents: What and Where are They?
Other	Canadian Life and Health Insurance Facts The Life and Health Insurance Consumer Assistance Centre
CompCorp	Consumer Protection Plan for Canadian Life and Health Insurance Policyholders

Policy searches

In 2000, the CAC received 1,821 requests from individuals either pursuing possible life insurance coverage of recently deceased persons or looking for possible misplaced policies of their own. In 117 of these cases, sufficient evidence existed to carry out formal policy searches. Sixteen policies were discovered, resulting in a positive "find" ratio of almost 14 per cent, which compares favorably with previous years.

Policy searches are conducted by both CLHIA member companies, and former member companies which contribute financially to the operations of the CAC. Requests come from heirs, beneficiaries, executors and law enforcement agencies. In 2000, 22 of the 117 requests resulted from police investigations.

CompCorp

Questions related to CompCorp came mainly from consumers who wished to confirm insurers' membership in the consumer protection plan and to clarify CompCorp guarantees for various products. More than 58 per cent of the product enquiries related to retirement products.

The number of enquiries concerning CompCorp declined from 2,301 in 1999 to 1,367 in 2000, no doubt reflective of consumer confidence in the safety of the industry.

Other

The "Other" category includes requests for general industry information and for assistance locating government services or departments.

Complaint resolution

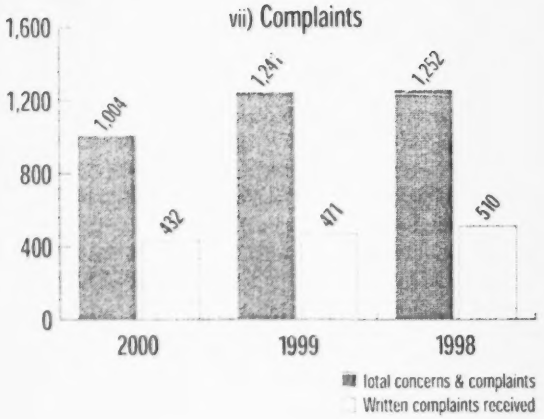
In 2000, as shown in Chart vii, the CAC received a total of 1,004 consumer concerns or complaints, representing 1.4 per cent of the almost 72,000 enquiries. These were submitted either in writing (258 letters) or over the phone (746 calls).

Of the 746 complaints discussed over the phone, 572 or almost 77 per cent, were either resolved by the counsellor during the initial telephone contact or the consumer elected not to pursue the matter further by writing to the CAC. In the remaining 174 telephone complaints, about 23 per cent, the consumers proceeded to submit their concerns in writing.

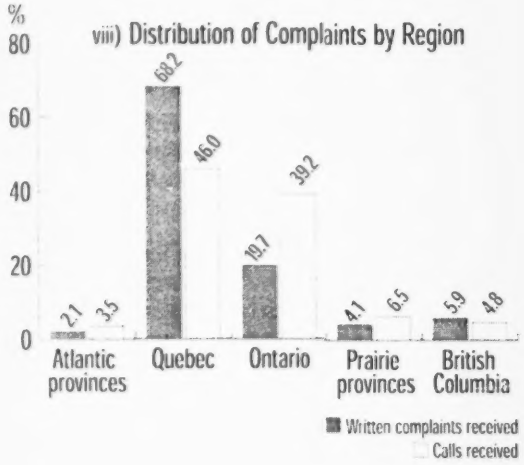
In total, the CAC received 432 written requests for assistance and as of year end, 26 of these were still pending and 232 had been responded to by the CAC, which provided explanatory information or requested further information in order to formulate the best possible response.

The remaining 174 written requests for assistance were referred to the Presidents of the companies in question for review and a response sent directly to the consumer. Of these, 36 were still under review at time of writing. Of the 138 completed cases, the companies involved either provided additional information or modified their positions in favour of the consumer in 109 cases or 79 per cent, and maintained their positions in 29 cases or 21 per cent.

vii) Complaints



viii) Distribution of Complaints by Region



Analysis of written complaints

Distribution of complaints by region

In 2000, as a new service, the CAC began analyzing the distribution of written complaints by the region in which they originated.

As Chart viii shows, in the Atlantic and Prairie provinces and in British Columbia, the percentage of complaints was roughly commensurate with the percentage of total calls. In Ontario, the percentage of complaints was about half the percentage of total calls.

In Quebec, the high number of complaints relative to calls is likely due to the fact that the Superintendent of Insurance and Financial Services Bureau routinely refer consumers with complaints involving life and health insurance to the CAC as a matter of government policy.

Complaints by company function

Complaints are classified according to the five main company functions detailed in Chart ix (one complaint can involve more than one function).

Historically, complaints involving claims-related issues have dominated. In 2000, they increased to almost 50 per cent of all complaints, while product- and service-related complaints declined.

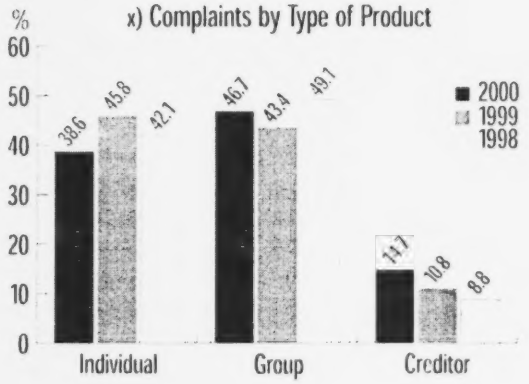
Complaints by type of product

Most complaints involve either group or individual products. The decline in individual complaints shown in Chart x parallels the decline in life insurance product complaints noted in Chart xi, which most often involve individual insurance. The increase in group insurance complaints can be attributed to the rise in disability product complaints, which most often involve group insurance.

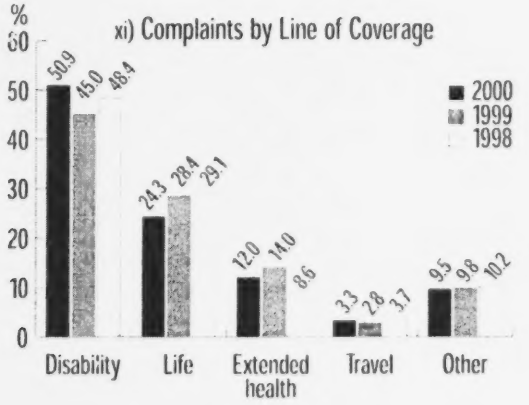
Complaints by line of coverage

Complaints involving disability products increased in 2000 after a gradual decline over the past two years, as shown in Chart xi. The decrease in complaints involving life insurance is in keeping with a similar decline in life insurance product enquiries (see page 5).

ix) Complaints by Company Function



x) Complaints by Type of Product



xi) Complaints by Line of Coverage

Life and disability

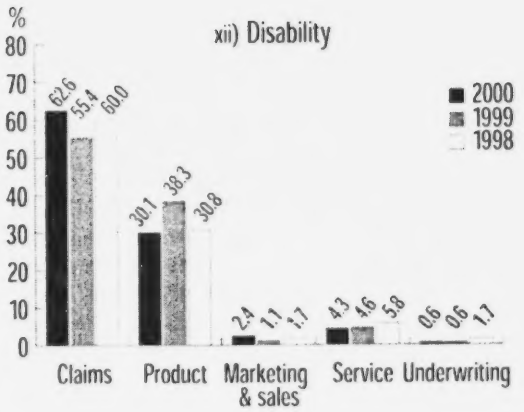
Further analysis of the predominant reasons for written complaints–disability and life insurance–follows.

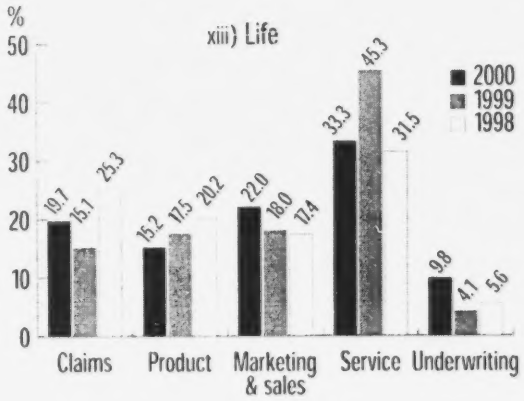
As in past years, claims-related issues dominated complaints involving disability insurance, as Chart xii shows. In 2000 the majority of these claims-related complaints–more than 53 per cent–involved the denial or discontinuation of benefits under a group disability policy. Product-related complaints about disability insurance tended to centre on the definition of disability in the consumer's policy.

Turning to life, with the exception of service and underwriting, complaints tended to be evenly distributed over all aspects of the business. As is evident from Chart xiii, complaints about service-related issues declined markedly in 2000, paralleling a similar decline in service-related complaints related to all products (page 9).

Other lines of coverage

In the remaining line of coverage categories, most complaints about extended health coverage and travel health insurance involved claims, while complaints about "other" products, which include accident and sickness insurance and retirement products, tended to involve claims and service issues respectively.





Ombudservice

What is the OmbudService?

The OmbudService is an informal conciliation service for consumers who, having gone through the CAC's basic complaint resolution service, elect to pursue their concern or complaint further. The service is provided by trained and skilled OmbudService officers.

How does it work?

If on completion of the basic CAC complaint resolution process, a consumer wishes to pursue a matter further, they are provided with a letter and kit which, inter alia, ask for written details of the complaint and formal authorization of the OmbudService to discuss the case with the company.

An OmbudService Officer is assigned to review the information provided by the consumer. Through a series of discussions with the consumer and the company, the officer endeavours to find some "dry ground" between the two. This informal conciliation process offers the consumer an alternative to going to court to resolve a complaint.

OmbudService statistics

Of the 138 consumers whose complaints were reviewed at a senior level as the final step in the CAC's complaint resolution process last year, 17 or 12.3 per cent expressed an interest in pursuing the matter through the OmbudService and were sent information and authorization kits for review.

Most of these 17 OmbudService cases–almost 65 per cent–involved disability insurance products and 61 per cent centred on claims-related matters.

At year end, 10 of the 17 cases had been closed, while five were awaiting the consumer's authorization to proceed, and two were under review. Of the 10 cases closed, six were because the consumer elected not to proceed any further. Of the remaining four cases, the insurer's decision was revised in favour of the consumer in two cases and maintained in two.

Since inception

The OmbudService has received a total of 44 requests for assistance since September, 1998. Five cases are awaiting authorization from the consumer (as noted above), and in 11 cases, the policyholders elected not to pursue the matter.

Of the 28 cases handled by the OmbudService, two are currently under review. Of the 26 cases closed, the insurer's position was maintained and additional information provided to the consumer in 20 cases, while in six, or 23 per cent of cases, the insurer's position was modified in favour of the policyholder.

Holocaust Support Service

The CAC operates a dedicated, toll-free telephone service for anyone seeking information on insurance proceeds possibly owing to survivors of the Holocaust and Holocaust victims' heirs. The service was established in November, 1998, after a request for assistance from the Canadian Jewish Congress.

Although Canadian life insurance companies did not operate in continental Europe during the years 1930 to 1945, it is nonetheless possible that Canadian insurers operating in other countries, such as the United Kingdom, sold policies to people who subsequently became victims of the Holocaust.

The objective of the service is to put individuals in touch with such Canadian insurers, or with other organizations in other countries that help Holocaust survivors and the heirs of Holocaust victims locate unclaimed insurance policies on a worldwide basis.

One such organization, the International Commission on Holocaust Era Insurance Claims (ICHEIC), launched a toll-free North American call centre in February, 2000, dedicated to providing information and assistance resolving claims. As a result, the number of calls handled by the CAC's Holocaust support service has dropped from 160 in 1999 to 13 in 2000.

The CAC service has responded to 266 enquiries since inception. Of these, more than 50 per cent were from people who simply wanted to explore the possibilities, and 21 per cent were from individuals who wanted to enquire about possible unclaimed benefits from a specific carrier. The remaining calls were from people enquiring about the service itself (9 per cent); about compensation for other wartime losses, such as the wrongful death of a family member, imprisonment or forced labour (14 per cent); and about unclaimed bank accounts (4 per cent).

Advisory Board

In April, 2000, the CLHIA enhanced and strengthened the industry's Consumer Assistance Centre by establishing a seven-person Advisory Board under the Chairmanship of the Honourable Gilles Loiselle, former federal Minister of Finance. Other members of the Advisory Board are:

- Lea Algar, former Ontario Insurance Ombudsman;
- Bernard Bonin, former Senior Deputy Governor of the Bank of Canada;
- Sally Hall, former President of the Consumers' Association of Canada;
- Madeleine Plamandon, President and Director, Service d'aide aux consommateurs de Shawinigan;
- Yves Rabeau, Professor of Economics, Université du Québec à Montréal (UQAM);
- Reginald Richard, former Superintendent of Insurance for New Brunswick

The CAC Advisory Board and its two sub-committees convened on a total of three occasions in 2000 to provide guidance on the CAC's overall priorities, directions, service mix and performance with a view to maximizing its usefulness to consumers.

Document d'information sur le Programme de prestations d'invalidité du RPC et l'assurance privée

Présenté aux : Bureau du Commissaire des tribunaux de révision

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Document d'information sur le Programme de prestations d'invalidité du RPC et l'assurance privée

Lien entre le Programme de prestations d'invalidité du RPC et les régimes de l'industrie des assurances-invalidité privées

Introduction

En règle générale, les revenus additionnels des prestataires du Programme de prestation d'invalidité du RPC (PPIRPC) proviennent de régimes d'assurance-invalidité privés. Selon une enquête menée par Statistique Canada en 1995 et commandée par Développement des ressources humaines Canada (DRHC), environ 25 pour cent des prestataires du PPIRPC touchaient des prestations d'assureurs privés, 17 pour cent en recevaient de régimes d'indemnisation des travailleurs et 13 pour cent touchaient des prestations d'aide sociale. Dans l'ensemble, plus de 60 pour cent des prestataires du PPIRPC touchaient des revenus d'assurance-invalidité émanant d'un autre programme de sécurité du revenu. [1]

Compte tenu de l'importance qu'occupe l'assurance-invalidité privée chez les prestataires du PPIPRC, nous pensons qu'il convient d'explorer les différentes facettes de l'assurance-invalidité privée, l'industrie des assurances et la façon dont les régimes publics et privés s'imbriquent entre eux, pour mieux comprendre les liens qui existent entre ces deux types de régimes.

Le lien entre le RPC et l'assurance-invalidité privée

Les prestations du PPIRPC ne peuvent pas constituer l'unique source de soutien ou de remplacement du revenu des prestataires. Des restrictions statutaires s'appliquent au niveau des prestations du RPC. Le Régime de pensions du Canada est conçu pour remplacer environ 25 pour cent du maximum des gains annuels ouvrant droit à pension (MGAP). Le MGAP correspond au salaire moyen par activité économique; en 2001, le niveau maximum de prestation d'invalidité permis s'élevait à 11 221 $. Il est entendu que d'autres formes de remplacement du revenu viendront compléter les prestations du RPC.

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[1] *Rapport du vérificateur général du Canada de 1996* (Ottawa : Imprimeur de la Reine pour le Canada, 1996), paragraphe 17.116.

Le RPC à titre de « premier payeur »

Le PPIRPC est perçu comme « premier payeur » par la plupart des régimes d'assurances privés et par un nombre croissant de programmes provinciaux d'indemnisation des travailleurs. Cela signifie que le calcul des prestations d'invalidité du RPC ne tient pas compte des prestations versées par d'autres programmes et, inversement, que ces autres régimes d'assurance ne tiennent pas compte des prestations d'invalidité du RPC dans le calcul des prestations auxquelles l'assuré a droit. Il est important de noter que cette perception ne repose sur aucune base statutaire précise, mais simplement sur une hypothèse de la méthode de calcul du RPC. Le vérificateur général a évalué l'admissibilité à la prestation d'invalidité du RPC dans son rapport de 1996 et son analyse étaye cette hypothèse :

> Le Régime de pensions du Canada ne prévoit aucune disposition concernant des prestations d'invalidité provenant d'autres sources, sauf pour permettre de rembourser des avances payées par d'autres régimes. Comme on ne tient pas compte des prestations d'autres régimes, le Régime est placé dans une position de premier payeur.[2]

D'autres affirment que cette notion de « premier payeur » s'inscrit dans le droit fil de l'intention originale du RPC, qui était de tenir compte des liens entre le RPC et d'autres payeurs, incluant les assureurs privés, et de ne constituer qu'un volet d'un système de pensions à plusieurs niveaux. [3]

La plupart des régimes d'invalidité de longue durée s'harmonisent avec les prestations du RPC et prévoient que leurs prestations, majorées de toute autre prestation reçue, ne doivent pas dépasser un pourcentage précis des gains habituels du bénéficiaire.[4] Cette intégration se produit peu importe si le revenu total du bénéficiaire est entièrement tiré du régime privé ou s'il s'agit d'une combinaison des prestations du RPC et du complément provenant du régime privé. Les sociétés d'assurances privées précisent également que les primes font l'objet d'un rajustement actuariel qui tient compte du fait qu'elles agissent comme second payeur et que les primes seraient plus élevées si le RPC n'existait pas.[5]

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[2] *Ibidem* paragraphe 17.132.

[3] S. Torjman, « Read the Fine Print » (Avril 2001) observations dans Caledon, page 4.

[4] *Faits sur les assurances de personnes au Canada, 2001* (Toronto : ACCAP, 2001), page 13.

[5] Note 3 ci-dessus.

La plupart des sociétés d'assurances privées demandent à leurs assurées de présenter une demande au PPIRPC et de faire appel en cas de refus. Bon nombre de polices indiquent également que le non-respect de cette condition pourrait avoir pour effet de suspendre ou de réduire les prestations d'invalidité en fonction du montant estimatif de la prestation d'invalidité du RPC. Il semble s'agir d'une pratique courante et faire partie des formulaires habituels propres à la plupart des polices d'assurances privées. (Voir annexe « A »)

La législation sur le RPC autorise l'intégration des prestations

Le *Régime de pensions du Canada*[6] prévoit expressément l'intégration des prestations émanant des régimes d'assurances publics et privés. Le paragraphe 65(3) de la Loi, ainsi que l'article 76.1 du Règlement prévoient le versement d'un montant forfaitaire de prestations d'invalidité aux organismes gouvernementaux et sociétés d'assurances dans le cadre d'ententes en vertu desquelles une personne est admissible à la fois aux prestations du RPC et à celles d'une assurance privée et qui tient compte de l'harmonisation des régimes. En vertu de ces « ententes », le « montant » de la prestation d'invalidité est versé à l'avance par la société d'assurances, qui est jugée « administrateur du programme de revenu d'invalidité » et ensuite remboursé une fois que la demande de prestation du PPIRPC devient payable.[7] Cette modification à la Loi et au Règlement est entrée en vigueur le 1er juin 1993 et plusieurs ententes avec les régimes d'assurance privés ont été conclues en vertu de cette disposition.

La législation uniforme[8] permet l'intégration des prestations

La législation uniforme sur laquelle reposent les régimes d'assurance privés provinciaux et territoriaux énonce les conditions statutaires devant faire partie de tout contrat d'assurance. La législation uniforme prévoit des dispositions visant la coordination des prestations entre les différents programmes de remplacement du revenu.

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[6] *Régime de pensions du Canada*, S.R. 1985, c. C-8.

[7] Il est à noter que la seule condition importante de l'entente est que l'administrateur du programme de revenu d'invalidité n'applique pas le principe de compensation dans le cas de la prestation pour enfants payée au cotisant du PPIRPC.

[8] « Législation uniforme » désigne un modèle de législation d'assurance adopté par l'ensemble des provinces et des territoires régis par la *common law* touchant l'assurance vie, accident et maladie.

La condition 4 de l'article 300 de la *Loi sur les assurances*[9] de l'Ontario prévoit la coordination partielle des prestations lorsqu'un assuré est admissible aux prestations de plus d'un contrat d'assurance-invalidité. Cette disposition s'applique uniquement lorsque l'assurance invalidité fait partie d'une police d'assurance accident et maladie ainsi qu'aux polices qui prévoient le versement de prestations calculées au prorata du revenu de l'assuré avant l'invalidité. Elle précise, lorsque les prestations cumulatives de l'assuré dépassent le revenu qu'il touchait avant l'invalidité, que l'assureur n'est tenu de payer qu'une partie proportionnelle des prestations totales auxquelles l'assuré a effectivement droit et que toute prime excédentaire doit être remboursée.

Cette disposition fait en sorte que l'assuré invalide ne recevra *jamais* de prestations supérieures à une proportion prédéterminée de son revenu, peu importe s'il pourrait légitimement avoir droit à des prestations en vertu de plusieurs régimes d'invalidité.

L'article 299 de la *Loi sur les assurances* de l'Ontario prévoit qu'en vertu de l'article 300, l'assureur doit prévoir dans ses polices toute exception ou réduction touchant le montant des prestations payables. Un agent d'assurance qui omettrait d'expliquer correctement l'effet d'une disposition sur l'intégration des prestations pourrait être coupable d'une négligence dont serait responsable la société d'assurances.[10]

Il n'existe aucun critère législatif régissant la façon dont les polices d'assurance privées doivent définir le revenu. En plus du régime d'indemnisation des travailleurs et du PPIRPC, certains régimes soustraient les gains du conjoint ou de la conjointe et en tiennent compte dans le revenu familial. Dans le cas de la prestation pour enfants du RPC par exemple, on a fait remarquer qu'il s'agit là d'une pratique qui va à l'encontre du but premier de la prestation. L'objectif législatif de cette disposition, qui prévoit le versement d'une prestation uniforme indexée, était de fournir un soutien additionnel au revenu en vue d'aider les familles lorsque le cotisant devenait invalide ou incapable de travailler. Le gouvernement reconnaissait ainsi que le fait que les besoins essentiels d'une famille pouvaient ne pas être comblés lorsque le cotisant devenait invalide ou incapable de travailler. En la soustrayant, les compagnies d'assurance

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[9] *Loi sur les assurances*, L.R.O. 1990, c. I.8.

[10] Voir *Theophanous c. Mutual of Omaha Insurance Company*, [1991] I.L.R. 1-2718 (Ont. Gen. Div.).

traitent cette prestation comme un remplacement du revenu et non un soutien du revenu.[11]

Harmonisation du RPC et de l'indemnisation des travailleurs

Le RPC est en voie de s'harmoniser peu à peu avec d'autres programmes gouvernementaux de sécurité du revenu, telle l'indemnisation des travailleurs. Il est possible de toucher à la fois des prestations d'invalidité du RPC et des prestations d'un programme d'indemnisation des travailleurs, parce que l'admissibilité au RPC n'est pas déterminée en fonction d'un motif lié au travail, contrairement à ce que prévoit l'indemnisation des travailleurs. L'indemnisation des travailleurs peut également offrir des prestations partielles dans le cas d'une perte partielle de capacité, contrairement à ce que prévoit le RPC.

La plupart des programmes d'indemnisation des travailleurs étaient perçus à l'origine comme premiers payeurs. Certaines provinces harmonisent maintenant leurs programmes avec le RPC. La législation ontarienne en matière d'indemnisation des travailleurs, la *Loi de 1997 sur la sécurité professionnelle et l'assurance contre les accidents du travail*[12] tient compte des paiements d'invalidité du RPC dans le calcul des versements pour perte de revenus, c'est-à-dire qu'elle assimile le RPC au « premier payeur ».

Il n'existe aucune approche uniforme au pays quant à l'harmonisation de l'indemnisation des travailleurs et du PPIRPC. Certaines commissions d'indemnisation des travailleurs demeurent premier payeur (Alberta), tandis que d'autres soustraient de leur indemnité un certain pourcentage de la prestation du RPC, allant de 50 % (Saskatchewan) à 100 % (Ontario et Manitoba).

Durant la période allant de juin 1998 à mars 1999, DRHC a conclu des ententes de partage d'information avec cinq commissions provinciales des accidents du travail. Ces ententes prévoient le versement de prestations rétroactives dues aux bénéficiaires lorsque ces sommes doivent être récupérées par les commissions, en vertu des dispositions du *Régime de pensions du Canada* visant la cession des prestations[13].

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[11] Torjman, note 3 ci-dessus, page 5.

[12] L.O. 1997, c. 16, annexe A, par. 43(5).

[13] *Rapport du vérificateur général du Canada* (Ottawa: Imprimeur de la Reine pour le Canada, 1999), point 32.79.

Importance de la notion de « premier payeur » lorsqu'il s'agit du RPC

D'autres questions d'ordre pratique ou théorique entrent en jeu dans l'analyse du rôle du RPC à titre de « premier payeur » et de l'intégration et l'harmonisation d'autres types de revenus d'invalidité qui s'ensuivent.

1) Quelles sont les répercussions de l'intégration et de l'harmonisation des prestations sur l'ensemble du niveau de prestations offert aux personnes invalides?

2) Quelles sont les répercussions d'une intégration accrue des prestations sur la nature du contrat d'assurance-invalidité même?

3) Existe-t-il une distinction théorique entre l'harmonisation de deux programmes gouvernementaux et l'harmonisation d'un programme gouvernemental et privé?

Répercussions de l'intégration/harmonisation sur les niveaux de prestations

Il ne fait aucun doute que l'intégration a pour effet de restreindre le niveau global des prestations d'invalidité offert aux demandeurs. On a justifié cette notion ainsi : sans intégration, une personne invalide pourrait recevoir des prestations égales ou supérieures au revenu d'emploi qu'elle touchait avant l'incapacité. Il s'agit là d'un enjeu qui dépasse la portée de la présente analyse mais qui devrait néanmoins être abordé. Quel serait le montant des prestations versées à un bénéficiaire admissible et qui fixerait ce montant?

Pour comprendre la façon dont l'intégration peut influer sur les niveaux de prestations, il faut aussi comprendre les différents modes de traitement fiscal du soutien du revenu. Lorsque l'employeur paie en tout ou en partie le coût d'un régime de remplacement du revenu, la prestation d'invalidité périodique versée dans le cadre d'un tel régime devient un revenu imposable. Lorsque l'employé assume entièrement de tels coûts, la prestation n'est pas jugée comme étant un revenu et n'est par conséquent pas imposable[14]. Les prestations d'invalidité du RPC sont pleinement imposables parce que l'employeur et l'employé y cotisent à la fois. (Les travailleurs indépendants cotisent à la fois à titre d'employeur et d'employé, c'est pourquoi ils sont pleinement imposés.) Les prestations d'indemnisation des travailleurs doivent être ajoutées au revenu mais sont entièrement déductibles d'impôt[15].

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[14] *Loi de l'impôt sur le revenu*, S.R.C. 1985, c. 1 (5e Suppl.), al. 6(1)f); IT-428, « Régimes d'assurance salaire » (30 avril, 1979).

[15] *Ibidem*, al. 56(1)v); s-al.110(1)f)(ii).

Il est important de noter que les prestations du RPC qui sont cédées à un « administrateur » en vertu des dispositions de la Loi et du règlement sur le RPC visant l'intégration, mentionnées précédemment, demeurent pleinement imposables pour le bénéficiaire même si elles sont directement cédées au programme d'assurance et jamais perçues par ce bénéficiaire.

Du point de vue du réclamant, plus le montant de la prestation tirée du RPC et de l'assurance privée (lorsque l'employé a cotisé au régime) est élevé, moins le niveau global de la prestation est élevé et plus les incidences fiscales sont importantes. Dans les provinces où l'indemnisation des travailleurs agit comme premier payeur et ne soustrait pas les prestations du RPC, le réclamant admissible à l'indemnité reçoit des prestations plus élevées qui ne seront pas imposées.

Le degré d'incapacité de bon nombre de personnes invalides n'est peut-être pas suffisant pour s'inscrire dans la définition de l'invalidité prévue au RPC ni répondre aux critères de cotisation au régime, mais les assureurs privés *tiendront compte* de la prestation du RPC lorsqu'il s'agira de déterminer le niveau des prestations applicables, même dans les cas où le montant payable du RPC n'est pas établi et, par conséquent, n'est pas directement retenu. (Voir exemple, annexe « B »)

Répercussions de l'intégration/harmonisation sur le contrat même

Selon R. Hayles[16], la prolifération des clauses de « coordination des prestations » des polices d'assurance-invalidité qui dressent une liste précise des paiements de remplacement du revenu à soustraire de la prestation payable, et la pratique répandue d'ajouter les prestations au calcul des revenus, font en sorte que ces polices sont passées d'un contrat à caractère non indemnitaire à un contrat à caractère indemnitaire.

Les polices d'assurance-vie et invalidité ont traditionnellement été perçues comme des contrats non indemnitaires. Les prestations sont versées lorsqu'il y a preuve que l'éventualité assurée s'est produite, sans qu'il ne soit exigé de prouver de perte financière réelle. Il est entendu que les contrats à caractère indemnitaire sont des contrats en vertu desquels l'assureur convient de dédommager l'assuré relativement à une perte financière découlant d'un risque assuré. Ils exigent la preuve tangible de la perte financière, comme dans le cas d'une assurance-habitation

[16]R. Hayles, « *Disability Insurance: Canadian Law and Business Practice* », (Toronto: Carswell, 1998) pages 268 et 277.

ou automobile. Compte tenu de la nature physique de l'objet assuré, la perte financière est plus évidente dans ce type de contrats, comparativement à l'assurance-vie ou l'assurance-invalidité.

L'évolution du traitement de l'assurance-invalidité, qui devient alors un contrat à caractère indemnitaire plutôt que non indemnitaire, a pour effet de mettre différents éléments de la police en relief, ce qui entraîne des conséquences importantes pour l'assuré. Il en résulte une baisse du niveau général de prestations auquel ont droit les bénéficiaires de polices d'assurance-invalidité privées. En outre, le prestataire invalide se voit contraint de présenter une demande ou de faire appel au PPIRPC et de comprendre comment cette interaction complexe de prestations et leur traitement fiscal vont influer sur le niveau global de remplacement du revenu.

Ce changement radical dans le traitement accordé par les sociétés d'assurance aux contrats d'assurance-invalidité soulève un enjeu important : est-ce bien là la façon d'envisager l'assurance-invalidité?

Répercussions de l'harmonisation sur la notion d'assurance-invalidité

On pourrait avancer qu'il serait acceptable que les programmes de sécurité du revenu gouvernementaux harmonisent les prestations payables pour des motifs semblables. Lorsqu'une invalidité découle d'un accident lié au travail, il semblerait tout à fait logique que les programmes d'indemnisation des travailleurs agissent comme premier payeur. Y aurait-il toutefois des conséquences sur le plan théorique si le RPC devenait second payeur au regard d'autres programmes gouvernementaux de soutien du revenu, telle l'indemnisation des travailleurs? Certains ont avancé que nous pourrions assister à l'érosion du statut du RPC à titre de programme universel : « En assumant le rôle de second payeur, le RPC pourrait devenir un programme résiduel plutôt qu'un régime d'assurance qui garantit une protection à tous ceux qui y ont versé les cotisations requises.[17] »

Le Québec est doté de ses propres lois régissant les régimes de pensions ainsi que d'un régime tout à fait différent en ce qui a trait au traitement de l'invalidité. Au Québec, l'indemnisation des travailleurs et le programme d'invalidité du RRQ s'excluent mutuellement. Le programme d'indemnisation des travailleurs du Québec, la Commission de la santé et de la sécurité du travail, est le premier payeur au regard du programme d'invalidité du RRQ et, en fait, constitue l'unique payeur. Les personnes dont l'incapacité découle de leur emploi peuvent

[17]S. Torjman, « La prestation d'invalidité du Régime de pensions du Canada » (février 2002) Caledon Institute of Social Policy, page 52.

recevoir une aide financière de l'indemnisation des travailleurs ou du programme d'invalidité du RRQ, mais non pas des deux. Dans le passé, le Québec semble avoir dirigé la plupart de ses dossiers d'invalidité vers l'aide sociale plutôt que vers le RRQ, quoique cette situation pourrait être appelée à changer compte tenu des pressions financières exercées sur un programme tel celui de l'aide sociale, qui est entièrement financé par le gouvernement[18].

L'industrie privée des assurances

Les sociétés d'assurances ont le même statut juridique que les autres sociétés au Canada. Elles ont les mêmes capacités, droits, pouvoirs et privilèges qu'une personne physique (article 15 de la *Loi sur les sociétés d'assurances*[19]). Les sociétés d'assurances constituées en vertu d'une loi fédérale peuvent faire affaire n'importe où au Canada et dans toute autre juridiction étrangère, en vertu des lois de celle-ci. La régie d'entreprise des sociétés d'assurances est également semblable à celle des sociétés privées. Elles peuvent mettre en œuvre des plans d'organisation interne semblables à ceux des autres sociétés constituées en vertu d'une loi fédérale.

Au Canada, l'industrie de l'assurance-vie et de l'assurance-santé est devenue largement établie, hautement concurrentielle, financièrement puissante et influente. L'Association canadienne des compagnies d'assurance de personnes (ACCAP), organisme sans but lucratif composé de sociétés d'assurance-vie et d'assurance-santé qui gèrent l'autoréglementation de l'industrie, a déclaré que les actifs de l'industrie dépassaient les 267 milliards de dollars[20].

L'industrie joue un rôle important au chapitre du soutien des finances des trois paliers de gouvernement, par le biais des valeurs qu'elle détient (25,1 milliards de dollars en valeurs fédérales, 29,4 milliards de dollars en valeurs provinciales et 2,7 milliards de dollars en valeurs municipales). Ses placements dans les marchés étrangers sont également importants : 49,1 milliards de dollars ou 55 % des primes émanent des marchés étrangers[21].

Dans la foulée de dix années de consultation avec l'industrie des assurances privées, une

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[18] *Ibidem*, page 41.

[19] *Loi sur les sociétés d'assurances*, L.C. 1991, c. 47.

[20] Association canadienne des compagnies d'assurance de personnes, *Faits sur les assurances de personnes au Canada, 2001* (Toronto : ACCAP, 2001), page 2.

[21] *Ibidem*, pages 2-3.

nouvelle loi fut adoptée au début des années 90, la *Loi sur les sociétés d'assurances*[22]. La loi autorise l'industrie à diversifier et élargir à la fois ses placements et ses activités commerciales. L'industrie des assurances peut investir ses actifs dans l'immobilier, les prêts hypothécaires (résidentiels et commerciaux), les fonds mutuels, les actions et obligations (industrielles et gouvernementales). Ses activités commerciales peuvent s'étendre à ce qui suit : services-conseils en investissement, gestion de portefeuille, émission et administration de cartes de crédit de concert avec les banques ou les compagnies de fiducie, le courtage immobilier et l'administration de biens immobiliers.

L'objet des quelques restrictions qui s'appliquent aux activités des sociétés d'assurances est de préserver la distinction (qui s'amenuise) entre les sociétés d'assurances et les banques ou sociétés de fiducie. Par conséquent, une société d'assurances ne peut agir à titre d'exécuteur ou d'administrateur testamentaire, ni de fiduciaire, et ne peut accepter de dépôts.

Parallèlement à cette incursion ascendante de l'industrie des assurances dans le domaine des institutions financières, on constate également la croissance des exigences face au gouvernement. L'ACCAP a fait pression auprès du gouvernement fédéral en vue de faire modifier la politique gouvernementale de façon à permettre à l'industrie de faire concurrence aux institutions de dépôt. L'ACCAP mentionnait ce qui suit dans le document qu'elle présentait en 1997 à un groupe de travail fédéral chargé d'analyser le secteur des services financiers canadiens :

> Le cadre de la politique gouvernementale continue de se caractériser par bon nombre d'iniquités concurrentielles issues de ces politiques et qui défavorisent les sociétés d'assurance-vie et d'assurance-santé comparativement aux institutions de dépôt. Le Trésor ainsi que les garanties de l'État conférées à la SADC, comparativement à la SIAP de l'industrie[23], qui ne jouit ni de l'un ni de l'autre, en sont un exemple probant. De plus, l'exclusion de l'industrie du système de paiement national est un autre exemple d'iniquité dans les règles du jeu qui ralentit le dynamisme de la concurrence[24].[Traduction]

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[22]*Loi sur les sociétés d'assurances*, L.C. 1991, c. 47, par. 440-441; 490-514.

[23]La SIAP est une société d'assurances organisée et financée par l'industrie pour indemniser les prestataires de polices d'assurance-vie et d'assurance-invalidité de sociétés membres qui sont incapables de toucher leurs prestations en raison de l'insolvabilité d'une société membre.

[24]Association canadienne des compagnies d'assurance de personnes Inc., « Canada's Life and

Bien qu'au-delà de la présente analyse, on pourrait s'interroger à savoir si une industrie essentiellement autoréglementée devrait avoir accès au Trésor (fonds général où sont recueillis l'ensemble des revenus du gouvernement fédéral), au même titre qu'un programme gouvernemental financé et réglementé par l'État.

Le contrat d'assurance-invalidité privé

Le contrat d'assurance privé suit un libellé-type. Cela signifie que la délivrance, l'exécution et souvent les conditions des polices d'assurance-invalidité sont régies par une législation uniforme. Cette législation a été conçue par le surintendant des assurances des provinces, dans le cadre d'une série de conférences fédérales-provinciales tenues en 1914, dans la foulée d'un consensus voulant que le marché de l'assurance en pleine expansion devait être réglementé.

Deux types de législation uniforme ont été conçus en ce qui a trait à l'« assurance de personnes » : la législation sur l'assurance-vie et la législation uniforme sur l'assurance-accident et l'assurance-maladie. À quelques variations mineures près, cette législation uniforme existe dans toutes les provinces et tous les territoires régis par la *Common law*.

Le modèle de législation en matière d'assurance-vie se trouve à la partie V de la *Loi sur les assurances* de l'Ontario. Il s'applique à l'assurance-invalidité offerte dans le cadre d'une police d'assurance-vie. Le modèle de législation sur l'assurance-accident et l'assurance-maladie se trouve à la partie VII de la *Loi sur les assurances* de l'Ontario et s'applique à l'assurance-invalidité lorsque celle-ci fait partie d'une politique d'assurance-accident et d'assurance-maladie. Il faut d'abord connaître la classification d'une police d'assurance afin de savoir quelle partie de la Loi s'y applique et la classification dépend de l'importance de la prestation de décès offerte par la police.

Cette distinction est importante. L'article 184 de la *Loi sur les assurances* de l'Ontario

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Health Insurance Industry : Structural and Business Powers Framework. Submission to the Task Force on the Future of the Canadian Financial Services Sector » (octobre 1997) .

précise que la règle d'incontestabilité ne s'applique *pas* à l'assurance-invalidité visée par la partie V de la Loi. La règle de l'incontestabilité est énoncée au paragraphe 184(2) :

> Sous réserve du paragraphe (3), lorsqu'un contrat a été en vigueur pendant deux années de la vie de la personne sur la tête de qui repose l'assurance, l'omission de divulguer un fait dont l'article 183 exige la divulgation ou une déclaration inexacte portant sur ce fait ne rend pas, sauf en cas de fraude, le contrat annulable.

Cela signifie que lorsqu'une assurance-invalidité fait partie d'une police d'assurance-vie (et non pas d'une police d'assurance-accident ou d'assurance-maladie), l'assuré n'est *pas* protégé par la règle d'incontestabilité et l'assureur peut annuler le contrat en tout temps si l'assuré omet de divulguer un fait ou effectue une déclaration inexacte. Il s'agit là d'une distinction qui pourrait avoir des répercussions importantes sur la situation d'un prestataire.

Les contrats d'assurance sont des contrats conclus « dans la bonne foi la plus entière »

Les contrats d'assurance sont généralement jugés comme étant des contrats conclus « dans la bonne foi la plus entière », et requièrent des deux parties d'aller bien au-delà du respect des obligations stipulées au contrat même. La notion de « la bonne foi la plus entière» appelle le respect absolu d'une obligation mutuelle d'honnêteté et de confiance. Dans cette optique, l'assureur tout comme l'assuré doivent pouvoir compter sur leur intégrité et leur bonne volonté mutuelles. Au tout début, l'assuré est en position de force, puisque l'assureur accepte un risque dont il connaît très peu la nature. Une fois que le contrat entre en vigueur, le rapport des forces glisse du côté de l'assureur, particulièrement lorsqu'il y a réclamation et que l'assuré est blessé ou malade, qu'il ne peut travailler et que ses revenus proviennent de l'assureur.

Les contrats d'assurance-invalidité ont déjà également été présentés comme des contrats assurant une certaine « tranquillité d'esprit ». L'affaire *Warrington* c. *Great-West Life Assurance Co.*[1] porte sur un différend au sujet du versement de prestations en vertu d'une police d'assurance-invalidité. La Cour d'appel de la Colombie-Britannique s'est penchée sur la question à savoir si un contrat d'assurance-invalidité était un contrat de « tranquillité d'esprit », qu'elle a défini ainsi :

> La voie menant à la guérison était libre dans au moins l'une des catégories de cas souvent appelés cas de « tranquillité d'esprit » -

[1] *Warrington* v. *Great West Life Assurance Co.*, [1996] 39 C.C.L.I. (2d) 116n (B.C.C.A..).

> c.-à-d. les situations où l'essence même du contrat est de procurer à l'assuré une certaine tranquillité d'esprit, voire une certaine satisfaction, alors que l'inverse s'est produit dans les faits[2]. [Traduction]

La Cour a affirmé qu'un contrat de ce type était un contrat de « tranquillité d'esprit », puisqu'elle a pris en compte les effets du refus de la société d'assurance de verser les prestations dues à M. Warrington aux termes du contrat :

> Sa maladie était de nature à être exacerbée par le stress. Il me semble que l'on souscrit à une assurance-invalidité précisément pour éviter ce genre de souffrance morale et d'inconvénient – en d'autres termes, l'*objet* de ce contrat était le confort et la tranquillité d'esprit de M. Warrington[3]. [Traduction]

La Cour a également déclaré que la nature des contrats d'assurance-invalidité peut donner lieu à des dommages-intérêts exemplaires. Elle a statué qu'une police d'assurance-invalidité constitue l'un des rares contrats dans le cadre desquels des dommages-intérêts peuvent être obtenus si la souffrance morale découle du non-respect du contrat même.

L'importance de la notion de devoir dans la bonne foi la plus entière et de « tranquillité d'esprit » dans le cas de contrats d'assurance a été confirmée récemment par la Cour Suprême dans l'affaire *Whiten* c. *Pilot Insurance Co.*[4] La cause portait sur un différend concernant le paiement d'une réclamation en vertu d'un contrat d'assurance-habitation, mais abordait également la notion de bonne volonté et de traitement équitable inhérent aux contrats d'assurances. La Cour a soutenu ces principes en maintenant les dommages-intérêts punitifs élevés accordés par le jury pour bris de contrat de la part de la société d'assurances :

> Comme l'indique le portrait que la société Pilot brosse d'elle-même, la tranquillité d'esprit est l'argument qu'invoquent les assureurs pour vendre leurs contrats d'assurance et la raison qui incite les membres du public à les acheter. Plus la perte est catastrophique, plus l'assuré risque de se trouver financièrement à la merci de l'assureur et plus il peut lui être difficile de contester

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[2] *Ibidem*, page 127.

[3] *Ibidem* page 131.

[4] *Whiten* c. *Pilot Insurance Co.*, [2002] S.C.C. 18.

> un refus illégitime de verser l'indemnité demandée. La dissuasion est nécessaire. En raison de l'obligation qu'avait Pilot d'agir de bonne foi, la tranquillité d'esprit de l'appelante aurait dû être l'objectif de Pilot, qui n'aurait pas dû accroître la vulnérabilité de cette dernière comme tactique de négociation. C'est cette situation de dépendance et de vulnérabilité que Pilot a exploitée de façon inacceptable en l'espèce. Le jury a, semble-t-il, décidé qu'un vigoureux message de châtiment, de dissuasion et de dénonciation s'imposait, et il a donné ce message[5]. [Traduction]

Assurances et police collectives

Il est question d'assurance collective lorsqu'une police est émise à un assuré qui n'est pas un individu (contrairement à l'assurance individuelle) qui peut être responsable ou non du paiement des primes. L'assurance collective peut se présenter sous différentes formes. L'assuré est souvent une entreprise, qui cotise au nom de ses employés, ou un syndicat, une association professionnelle ou une organisation d'anciens élèves. Les banques et les compagnies de fiducie peuvent parfois offrir une assurance collective à leurs débiteurs hypothécaire. Les sociétés de financement peuvent conclure des ententes avec les assureurs afin d'offrir une assurance-invalidité ou une assurance-vie lors du financement d'un achat important, comme une automobile. Les détaillants et les institutions financières qui émettent des cartes de crédit peuvent également offrir des assurances collectives aux titulaires. Toute organisation ayant la capacité légale de conclure des marchés et qui est suffisamment rapprochée d'un groupe d'individus identifiable peut être admissible, sous réserve que le groupe ait été constitué à l'origine dans un but autre que de souscrire à une assurance[6].

L'émission d'une police collective ou d'une police de base établit un régime en vertu duquel une assurance est offerte aux membres du groupe. La police détermine le groupe de sorte que l'assureur et l'assuré (le titulaire) peuvent déterminer plus tard si un individu qui présente une demande y est admissible ou non. La police de base énonce la couverture, ainsi que les modalités et conditions qui s'appliquent et peut contenir une formule de calcul des primes payées par les membres du groupe. Le groupe de personnes assuré reçoit habituellement un certificat, mais sans copie de la police de base. Le certificat est habituellement un simple résumé des

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[5] *Ibidem*, paragraphe 129.

[6] Hayles, note 16 ci-dessus, page 93.

modalités de la couverture plutôt qu'un certificat complet[7].

L'assurance collective présente un certain nombre d'avantages comparativement à l'assurance individuelle. Elle peut être financièrement plus rentable pour l'assureur, parce qu'elle diminue les coûts de marketing ainsi que les coûts d'administration (si le titulaire de la police assume une partie du travail d'administration). Elle offre également des avantages à l'assuré. Les demandeurs individuels sont soumis à un examen moins rigoureux dans le cadre d'une assurance collective, c'est pourquoi les demandeurs qui présentent un plus grand risque ont de meilleures chances d'obtenir une couverture[8]. L'assureur offre également une protection à de nombreux individus en même temps, c'est pourquoi le coût élevé d'assurer ceux qui sont à haut risque est compensé par les coûts moins élevés d'assurer les membres du groupe qui sont en santé et à faible risque.

Questions d'ordre juridique entourant l'assurance collective

Bon nombre de questions d'ordre juridique sont soulevées par la notion d'assurance collective parce qu'un tiers devient partie au contrat, l'organisation contractante ou l'entreprise qui « détient » la police au nom des individus qu'elle assure. Bon nombre de ces questions ont été réglées par la jurisprudence. La question de la formule de contrat est abordée dans le cadre du droit contractuel. Quel est le statut juridique du groupe d'assurés? Sont-ils partie au contrat? Il a maintenant été établi que la personne faisant partie d'un groupe est partie au contrat collectif[9].

La question de la représentation est également un enjeu. Le titulaire de la police est-il un représentant de l'assureur? Dans l'affirmative, l'assureur est-il responsable des déclarations formulées par le titulaire de la police à l'assuré? Au Canada, les juristes pensent que le titulaire de la police représente effectivement l'assureur et que ce dernier est responsable des activités du titulaire auprès du groupe de personnes assuré à titre de représentant[10]. Certains ont également exprimé l'opinion qu'il y a représentation selon que l'assureur ou le titulaire de la police administre le régime.

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[7]Hayles, note 16 ci-dessus, page 93.

[8]Cela pourrait s'avérer faux en pratique. Veuillez vous reporter à la page 23 où on fait la preuve que de nombreux consommateurs se plaignent qu'on leur ait refusé ou retiré des prestations d'invalidité dans le cadre de polices d'assurance collective.

[9]*London Drugs* c. *Kuehne & Nagel International Ltd.*, [1992] 3 S.C.R. 299.

[10]*Tarailo* c. *Allied Chemical Canada Ltd.* (1989), 68 O.R. (2d) 288 (H.C.).

La jurisprudence maintient également que la loi de la responsabilité civile délictuelle s'applique aux contrats d'assurances compte tenu, comme nous le mentionnions précédemment, de la nature particulière des contrats d'assurances. Il a également été maintenu qu'un assureur peut être tenu responsable du fait d'autrui dans le cas où un titulaire de police a commis un acte délictueux ou une omission. Il existe également un enjeu à savoir si le titulaire de la police a une obligation de diligence envers la personne assurée par le biais d'une assurance collective, par exemple, en ce qui a trait à des déclarations négligentes quant à la portée de la couverture. Il ne semble pas y avoir non plus consensus à savoir s'il existe une obligation de diligence de la part du titulaire de la police et si une telle obligation englobe celle de fournir une explication exhaustive de l'assurance[11].

Mécanismes de surveillance

Surveillance gouvernementale

La surveillance de l'industrie des assurances privées ainsi que des contrats d'assurances privées s'effectue au niveau des gouvernements provinciaux et du gouvernement fédéral. Il est important de comprendre ce qui distingue les sphères de compétences fédérales et provinciales au chapitre des sociétés et des contrats d'assurances pour savoir où se situent les mécanismes de changement.

La surveillance et la législation fédérales portent principalement sur l'octroi de permis aux sociétés d'assurances, la régie d'entreprise des sociétés constituées en vertu d'une loi fédérale et les investissements et activités financières des sociétés d'assurances. Le gouvernement fédéral n'aborde pas les questions touchant les contrats d'assurances ni le marketing des produits d'assurance au public.

La législation provinciale aborde également la question de l'octroi des permis aux sociétés d'assurances (celles qui sont constituées en vertu d'une loi provinciale), mais constitue principalement l'autorité sur le lien contractuel entre assureur et assuré. La surveillance

[11] *Ibidem* et voir *Twardy* c. *Humboldt Credit Union Ltd.* (1985), 34 C.C.L.T. 140 (Sask. Q.B.).

provinciale englobe ce qui suit : le caractère exécutoire et le contenu des contrats d'assurances, la divulgation et la fausse représentation, l'application des doctrines de *common law* en matière d'assurance comme l'intérêt assurable et les conditions statutaires des polices d'assurance-maladie et accident.

Surveillance législative/réglementaire

Surveillance fédérale

Les lois et règlements fédéraux traitent de la sécurité financière, de l'organisation d'entreprise et de la solvabilité des entreprises constituées en vertu d'une loi fédérale et des entreprises étrangères. La *Loi sur les sociétés d'assurances* constitue la principale loi fédérale qui aborde toutes les facettes de la constitution en société, des finances d'entreprise et de l'organisation, ainsi que de la stabilité financière des sociétés d'assurances. Cette loi et son règlement d'application prévoient des dispositions en matière de protection du consommateur, mais il est important de noter qu'elle n'aborde que les questions de divulgation touchant les frais de carte de crédit ou les coûts d'emprunt sur la valeur de rachat d'une police et la mise sur pied de mécanismes de plainte touchant ce type de divulgation[1].

La Loi énonce également les pouvoirs du Surintendant des institutions financières en matière de supervision des opérations financières des sociétés d'assurances. Le Surintendant a l'autorisation de rendre des ordonnances pour obliger une société de cesser des pratiques financières commerciales dangereuses ou illogiques ou de prendre le contrôle des actifs d'une société incapable de respecter ses obligations ou dans le cas où ses actifs sont insuffisants pour protéger les titulaires de police ou les créanciers[2].

La *Loi sur le Bureau du surintendant des institutions financières*[3] est celle qui crée le poste de Surintendant des institutions financières et qui met sur pied le ministère gouvernemental chargé d'assurer le respect des lois fédérales qui s'appliquent aux sociétés d'assurances et autres institutions financières. Il est important de souligner que la mission du Bureau du surintendant en

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[1] *Loi sur les sociétés d'assurances*, note 22 ci-dessus, sous-sous-alinéa 165(2)*f*),*g*); paragraphes 479-489.2; paragraphes 598-607.1.

[2] *Ibidem*, paragraphes 676-692.

[3] S.C. 1987, c. 23.

ce qui a trait aux institutions financières vise uniquement à contrôler et à s'assurer la viabilité financière des institutions.

Le Surintendant a les pouvoirs, fonctions et attributions que lui confèrent différentes lois, incluant la *Loi sur les sociétés d'assurances* mentionnée précédemment. Le financement des activités du Bureau provient directement des industries qu'il supervise par le biais de fonds, déterminés au prorata, perçus auprès des institutions financières pour les coûts engagés dans la réglementation des différents secteurs de l'industrie financière.

La mise sur pied de *l'Agence de la consommation en matière financière du Canada* découle d'une récente initiative législative. L'agence a été créée en vue de renforcer la surveillance des questions de consommation ainsi que pour élargir les connaissances des consommateurs dans le domaine financier. Tout comme dans le cas du Bureau du surintendant des institutions financières, cette agence est entièrement financée à partir des fonds perçus auprès des institutions financières qu'elle réglemente. L'agence est présidée par un commissaire chargé de la supervision des institutions financières, qui doivent déterminer la conformité aux dispositions en matière de consommation qui s'appliquent à elles et de promouvoir l'adoption de politiques et de procédures visant la mise en œuvre de ces dispositions[4].

Il est important de souligner à nouveau que les dispositions en matière de consommation qui concernent les sociétés d'assurances et qui font l'objet de la supervision du commissaire sont les dispositions de la *Loi sur les sociétés d'assurances*, susmentionnée, qui traite uniquement des questions de consommation entourant la divulgation des frais applicables aux cartes de crédit et aux coûts d'emprunt.

Le commissaire a également l'autorisation de contrôler tout code d'éthique volontaire adopté par les institutions financières, conçu en vue de protéger les intérêts des consommateurs et accessible au public[5].

Surveillance provinciale

Comme nous le mentionnions précédemment, l'autorité provinciale dans le secteur des

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[4] *Financial Consumer Agency of Canada Act*, S.C. 2001, c. 9.

[5] *Ibidem*, alinéa 3(2)c). Cela signifierait probablement qu'il n'a aucun pouvoir de supervision en ce qui a trait aux lignes directrices qui régissent le fonctionnement des sociétés d'assurances membres. Voir note 42 ci-dessus.

assurances est beaucoup plus large que l'autorité fédérale. Ses pouvoirs englobent les suivants :

- constituer les sociétés qui ont un « objectif provincial »;
- accorder des permis aux assureurs et superviser les finances des sociétés constituées en vertu d'une loi provinciale;
- accorder des permis et réglementer les agents et les courtiers d'assurances;
- exercer une autorité sur le lien contractuel entre l'assureur et l'assuré qui englobe les questions de divulgation et de fausse déclaration ainsi que les questions touchant le caractère exécutoire et le contenu des contrats d'assurances[6].

Chaque province est dotée d'un bureau de réglementation ou d'un ministère, constitué en vertu d'une loi, chargé de surveiller les activités des sociétés d'assurances. En Ontario, le Surintendant des services financiers est l'autorité réglementaire dont les pouvoirs sont établis par la *Loi sur la Commission des services financiers de l'Ontario*[7]. Cette Loi établit également la Commission des services financiers de l'Ontario. Cette commission a pour objet de réglementer le secteur des institutions financières de l'Ontario, qui englobe les sociétés œuvrant dans le domaine des assurances et les entreprises visées par la *Loi sur les assurances* de l'Ontario. Le Surintendant est également autorisé à exécuter toute Loi lui conférant des pouvoirs telle la *Loi sur les assurances* de l'Ontario, dans le domaine des assurances.

La législation provinciale prévoit des dispositions qui accordent de vastes pouvoirs au Surintendant en ce qui a trait à la réglementation des contrats d'assurances et le lien entre assureur et assuré.

En vertu du paragraphe 51(1) de la *Loi sur les assurances* de l'Ontario, le Surintendant a les pouvoirs de faire rapport s'il pense qu'il existe une situation préjudiciable aux intérêts d'une personne ayant souscrit à un contrat d'assurances auprès d'un assureur autorisé de l'Ontario. Suivant ce rapport, le Surintendant peut suspendre ou annuler le permis d'un assureur.

Il existe également des dispositions visant spécifiquement les pratiques commerciales malhonnêtes ou mensongères. Ces pratiques sont définies dans le règlement et englobent les suivantes :

> 4. Toute illustration, circulaire, note ou déclaration qui présente de façon mensongère, ou par omission est si incomplète qu'elle présente de façon mensongère les modalités, les prestations ou les avantages de toute police ou contrat d'assurance émis ou à émettre.

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[6] Hayles, note 16 ci-dessus, page 72.

[7] *Loi sur la Commission des services financiers de l'Ontario*, S.O. 1997, c. 28.

5. Toute déclaration mensongère quant aux modalités, prestations ou avantages de tout toute police ou contrat d'assurance émis ou à émettre. d.[8]

En vertu des articles 438 et 441 de la Loi, le Surintendant est autorisé à faire enquête et à faire rapport dans le cas d'actes ou de pratiques malhonnêtes ou mensongères et de rendre une ordonnance :

a) de cesser ou de s'abstenir de commettre des actes ou de poursuivre une ligne de conduite que le Surintendant précise;
b) de cesser de se livrer à des opérations d'assurance ou aux activités liées à ces opérations que le Surintendant précise; ou
c) de prendre les mesures qui, de l'avis du Surintendant, s'imposent afin de remédier à la situation[9].

Mécanismes de rapport sur les plaintes

Fédéraux

Comme nous le mentionnions précédemment, le commissaire de l'*Agence de la consommation en matière financière du Canada* surveille les institutions financières, incluant l'industrie des assurances et peut s'assurer que l'industrie respecte les dispositions des lois fédérales en matière de consommation. Par contre, les dispositions touchant les plaintes des consommateurs des lois fédérales applicables régissant les assurances, la *Loi sur les sociétés d'assurances*, abordent uniquement les questions de plainte concernant la divulgation de frais de carte de crédit et de coût d'emprunt. Le contrat d'assurances même ou le lien entre les parties au contrats sont des éléments qui ne relèvent pas de la compétence fédérale.

Provinciaux

La législation provinciale varie en ce qui a trait aux mécanismes de plainte. L'Ontario est l'une des rares provinces dotées d'un ombudsman en matière d'assurance. En vertu de la *Loi sur les assurances* de l'Ontario, le Surintendant a le droit de nommer un Ombudsman d'assurance, qui est un employé de la Commission des services financiers.

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[8]Règlement de l'Ontario 7/00.

[9]*Loi sur les assurances*, note 9 ci-dessus.

L'Ombudsman d'assurance de l'Ontario a le droit d'enquêter à la suite de plaintes au sujet des pratiques commerciales des assureurs, pour tenter de résoudre des plaintes ou de présenter des recommandations au surintendant en vue d'enquêter au sujet d'une plainte. L'Ombudsman précise lui-même qu'il offre au consommateur un « ultime recours informel[10] ». Une personne peut présenter une plainte écrite au sujet des pratiques commerciales d'un assureur à l'Ombudsman si elle a déjà essayé de résoudre sa plainte directement auprès de sa société d'assurances et que cette plainte n'a pas été réglée dans un délai raisonnable. L'Ombudsman offre à l'assuré la possibilité de répondre à toute plainte. Après avoir étudié la plainte et la réponse, il peut tenter de résoudre la plainte ou recommander au Surintendant de faire enquête sur la plainte[11].

L'Ombudsman d'assurance précise en outre ses pouvoirs de la façon suivante : « Nos constatations ne lient ni l'une ni l'autre partie. Vous pouvez envisager de consulter un avocat si vous désirez poursuivre cette affaire plus avant[12]. »

Récemment, la Commission des services financiers de l'Ontario a élaboré des normes visant le système de traitement des plaintes des consommateurs en Ontario[13]. Elles exigent notamment la cueillette et la présentation des données sur les plaintes des consommateurs au Bureau de l'Ombudsman d'assurance (BOA) de façon trimestrielle, à compter du 1er janvier 2001 et l'élaboration de mécanismes visant à s'assurer que le plaignant est informé de son droit de présenter sa plainte au BOA.

Les dispositions spécifiques des directives mettent en relief certaines faiblesses importantes des nouvelles normes de rapport liées à la façon dont les plaintes sont définies et rapportées. Selon les directives, une « plainte devant être communiquée » est une plainte qui est révisée ou traitée à un échelon au moins une fois plus élevé que l'échelon qui s'occupe couramment du sujet de la plainte et qui prend les décisions de nature opérationnelle s'y

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[10]Commission des services financiers de l'Ontario, « Ombudsman d'assurance : Au travail pour vous », (Ontario : Imprimeur de la Reine, 2000).

[11]*Loi sur les assurances*, note 9 ci-dessus, paragraphe 5.1(3).

[12]Commission des services financiers de l'Ontario, note 43 ci-dessus.

[13]Commission des services financiers de l'Ontario, « Bulletin nº G-10/00 général » (7 novembre 2000).

rapportant[14]. » Il est surprenant de constater qu'une plainte devant être communiquée *n'englobe pas* celle d'un client qui doit être retournée en première ligne à l'échelon opérationnel, même si le client a tenté de la faire entendre à un « échelon supérieur »[15].

Il est difficile de comprendre la logique qui sous-tend la distinction entre une plainte qui serait « portée à un niveau supérieur » et une plainte qui serait retournée en première ligne à l'échelon opérationnel, puisque cette notion n'est pas expliquée. Deux autres scénarios proposés portent à confusion : 1) le client qui tente de déposer une plainte au sujet des pratiques de l'assureur peut être dirigé vers une « porte tournante », où les plaintes ne peuvent jamais atteindre un échelon supérieur ou de supervision au sein de la société d'assurances et 2) plusieurs plaintes ne pourront jamais atteindre le BOA parce qu'elles ne répondent pas à la définition arbitraire d'une « plainte devant être communiquée ».

Le formulaire de cueillette des données liées aux plaintes (voir annexe « C ») qui accompagne les directives comporte également certaines lacunes, c'est-à-dire qu'on n'y trouve pas suffisamment d'information au sujet du contenu des plaintes traitées par les sociétés d'assurances. Le formulaire n'indique rien au sujet de la nature de la plainte reçue par la société (les catégories fonctionnelles englobent la « plainte » et « divers »). Il s'agit simplement d'un résumé du nombre de plaintes ventilées par type de police. On ne voit pas comment cela répondra aux objectifs des directives selon lesquelles il y a lieu de comprendre la nature des plaintes traitées par les sociétés.

Enfin, on *demandera* aux sociétés de travailler de concert avec le BOA en vue d'élaborer un mécanisme qui permettra de s'assurer qu'un plaignant est informé de son droit de présenter une plainte à l'Ombudsman d'assurance de l'Ontario s'il n'a pas réussi à la régler durant une période donnée. De tels protocoles seraient en voie d'élaboration.

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[14]Bureau de l'Ombudsman d'assurance, « Directives – Collecte de données liées aux plaintes des consommateurs auprès des compagnies d'assurances », (novembre 2000).

[15]*Ibidem*.

Aperçu de l'industrie des assurances

Malgré la présence réglementaire du gouvernement fédéral et des gouvernements provinciaux, l'industrie des assurances doit se soumettre à l'autoréglementation. Les liens entre l'industrie des assurances et le public ainsi que les pratiques commerciales de l'industrie doivent être réglementées par l'industrie même. L'ACCAP administre les lignes directrices [1] qu'elle a elle même établies visant ses propres activités et pratiques. Les lignes directrices visent :

- la publicité entourant les produits d'assurance
- la communication au point de vente
- les activités des agents d'assurances
- les pratiques commerciales des sociétés d'assurances

L'ACCAP a également adopté un code d'étique qui donne corps aux principes qui sous-tendent les lignes directrices.

Il est important d'observer dans un premier temps que les lignes directrices ne sont que des directives qui n'ont pas force de droit. Elles avaient été élaborées à l'origine par les surintendants des assurances provinciaux et ont éventuellement été remplacées par les lignes directrices énoncées par l'ACCAP, de concert avec l'industrie des assurances. On a souligné par contre que l'industrie des assurances a tout à gagner en les respectant, afin d'éviter la réglementation obligatoire imposée par le gouvernement. Cependant, dans le cadre de l'autoréglementation, le public dispose de moyens limités pour évaluer cette affirmation, en l'absence d'un tiers impartial chargé d'évaluer la mesure dans laquelle la société respecte les lignes directrices.

Il ressort de l'examen des lignes directrices que celles-ci n'imposent pas de normes très rigoureuses aux sociétés d'assurances. Il existe des directives distinctes visant les assurances vie,

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[1] Le 20 mars 2002, j'ai tenté d'obtenir anonymement copie des lignes directrices en téléphonant le centre d'aide au consommateur de l'ACCAPainsi que le bureau local de l'organisme à Ottawa. Ma démarche n'a pas été fructueuse. L'agent du centre d'aide au consommateur m'a affirmé que les lignes directrices ne seraient pas intéressantes à lire parce qu'elles sont trop volumineuses et a insisté pour savoir ce qui me préoccupait particulièrement. Le bureau local d'Ottawa m'a dit que les lignes directrices s'adressaient uniquement aux sociétés membres et non pas au consommateur. Par conséquent, l'analyse du fondement des lignes directrices repose uniquement sur une source secondaire : *Disability Insurance: Canadian Law and Practice*, note 16 ci-dessus.

maladie ou accident et celles-ci ne s'appliquent qu'aux polices d'assurance individuelles. Les exigences visant la divulgation dans le cas des assurances collectives font l'objet d'une directive distincte.

La directive 39 vise les pratiques entourant la divulgation au point de vente dans le cas des polices d'assurance accident et maladie. Elle précise qu' une déclaration de divulgation doit être présentée à l'assuré au moment où il reçoit la police. La directive prévoit une période d'examen gratuit obligatoire de 10 jours durant laquelle l'assuré peut examiner un résumé des modalités de la police, lui permettant de résilier le contrat avant d'accepter la protection inconditionnellement. La déclaration de divulgation doit inclure une liste de tout paiement par un tiers, comme l'assurance-emploi, l'indemnisation des travailleurs ou le Régime de pensions du Canada ou Régime de pensions du Québec, pouvant diminuer la prestation lorsque la politique prévoit une clause d'intégration des prestations.[2]

Les directives entourant la divulgation dans le cas des polices d'assurance-vie sont beaucoup moins exigeantes que celles qui visent les polices d'assurance accident et maladie parce qu'elle prévoient une divulgation très restreinte. Les directives précisent qu'une société est tenu de remettre à chaque demandeur un avis écrit indiquant, qu'à sa *demande*, on lui transmettra copie d'un « guide d'achat d'une assurance-vie » ainsi qu'un résumé de la police. Le contenu de la divulgation est également très restreint. Les directives sont centrées sur les volets financiers de la police. Rien n'exige la divulgation ni l'explication des modalités et exclusions de la police.[3]

Mécanismes de rapport sur les plaintes de l'industrie

L'analyse des mécanismes de rapport sur les plaintes des consommateurs établis par l'industrie des assurances et de la nature des plaintes reçues révèle que le processus manque de transparence et que les plaintes en matière d'assurance-invalidité sont nombreuses.

L'ACCAP a mis sur pied un Centre d'assistance au consommateur chargé de recevoir les plaintes des consommateurs au sujet de l'industrie des assurances. Son processus de résolution n'est pas énoncé clairement dans ses brochures mais semble prévoir une première étape selon laquelle bon nombre de plaintes sont transmises à nouveau aux présidents des sociétés en

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[2]Hayles, note ci-dessus 16, voir 122.

[3]*Ibidem* voir 121.

questions, qui se chargeront de les étudier et de répondre directement au consommateur.[4] Le rapport annuel du centre pour l'année 2000 révèle également une prédominance de plaintes liées à l'assurance-invalidité (voir annexe « D »).

Lorsqu'une plainte d'un consommateur soumise au Centre n'est pas réglée au premier niveau, soit par téléphone ou par écrit (ou une plainte qui revient probablement au centre en dépit du fait qu'elle ait été retransmise à la société en question), elle est réglée au dernier échelon du processus. Un consommateur qui souhaite maintenir une plainte non réglée à l'échelon supérieur du Centre d'assistance au consommateur peut demander à l'Ombudsman d'étudier la question en son nom. L'agent de l'Ombudservice offre un service de conciliation informel et agit comme médiateur entre le consommateur et la société. Durant l'année 2000, 17 des 138 plaintes ont été transmises à l'Ombudservice. La majorité de ces plaintes (65 %) touche des produits d'assurance-invalidité.[5]

La plupart des plaintes déposées au Centre durant l'année 2000 touche les réclamations (48,9 %), suivi des plaintes au sujet d'un produit d'assurance (24,6 %). Les plaintes concernant une police d'assurance-invalidité constituent la majorité (50,9 %) des plaintes au sujet de la gamme de protection offerte.[6]

Le rapport annuel présente également une analyse des principaux motifs de plainte touchant l'assurance-invalidité. Les questions concernant les réclamations dominent les plaintes au sujet de l'assurance-invalidité (62,6 %) et plus de 53 % de celles-ci portent sur un refus ou la suspension des prestations dans le cadre d'une assurance collective. Les plaintes liées aux produits d'assurance-invalidité constituent 30,1 % des plaintes en matière d'assurance-invalidité et portent principalement sur la définition de l'invalidité formulée dans la police du consommateur.[7]

Tout mécanisme visant à faire rapport des plaintes au sujet d'une industrie et qui est

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[4]Association canadienne des compagnies d'assurances de personnes inc., « Centre d'assistance au consommateur – Compte rendu annuel 2000 », (ACCAP inc.: Toronto, 2000), p. 8.

[5]*Ibidem, p.* 11.

[6]*Ibidem, p.* 9.

[7]*Ibidem, p.* 10.

administré par cette même industrie soulève inévitablement certaines préoccupations quant à la capacité de toute organisation d'exercer une surveillance sur ses propres activités. Un mécanisme de plainte qui prévoit que la plainte soit retransmise à l'industrie ne propose pas de méthode impartiale de traitement des plaintes.

Conclusion

Ce tour d'horizon des régimes d'assurance publics et privés en matière d'invalidité soulève bon nombre de questions importantes sur la façon dont ces systèmes s'imbriquent et influent sur le bien-être des assurés invalides.

L'analyse met en relief certaines dispositions législatives ainsi que certaines pratiques de l'industrie qui encouragent et prévoient l'intégration des prestations publiques et privées et la compensation de ces prestations. Ces éléments ont engendré une profonde mutation de la notion de contrat d'assurance-invalidité au détriment des personnes invalides assurées. Ils ont strictement restreint le niveau de prestation offert aux personnes invalides et ont imposé aux réclamants un lourd fardeau d'obligations administratives et financières.

L'analyse fait également ressortir qu'il existe effectivement certains mécanismes de surveillance législatifs, dans la plupart des cas au niveau provincial, mais qui semblent mal utilisés. Parallèlement à cela, les mécanismes d'autoréglementation adoptés par l'industrie n'ont pas force de droit et manquent de transparence à l'égard du public.

D'autre part, les principes de *common law* confirment que la nature du contrat d'assurance, et particulièrement celle d'un contrat d'assurance-invalidité, transcende les principes habituels du droit contractuel. Les deux parties sont soumises à des normes plus élevées de bonne foi la plus entière et d'honnêteté. Ces principes réitèrent également que la tranquillité d'esprit où l'apaisement de souffrances morales font précisément partie du contrat de l'assuré. Les pratiques actuelles entourant l'assurance-invalidité ne sous-entendent pas le respect de l'un ou l'autre de ces principes.

Annexe "A"

LIVRET

Le présent régime est administré par
CANADIAN BENEFITS CONSULTING GROUP LTD.

Demandes de règlement d'invalidité de
courte durée payées par **CANADIAN BENEFITS**

2300 Yonge Street, Suite 3000
Toronto, Ontario
M4P 1E4
Téléphone: (416) 488-7755
Ligne sans frais : 1-800-268-0285
Télécopieur: (416) 488-7774

et est souscrit auprès de
LA GREAT-WEST LIFE, COMPAGNIE D'ASSURANCE-VIE
(antérieurement La London Life, Compagnie d'Assurance-Vie)

Demandes de règlement d'invalidité de longue durée payées par la
Great-West Life

IMPORTANTLa présente brochure est destinée à vous aider à mieux comprendre les modalités de votre régime collectif d'assurance revenu en cas d'invalidité.T outefois, **elle ne remplace aucun contrat ou autre droit**. S'il existe un conflit quelconque entre les termes de la police collective et ceux de la brochure, la police prévaudra en tout temps.

continuez

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CAW TCA
CANADA
LOCALE 2213

Regime Collectif D Assurance Revenu en Cas D Invalidit? (GIDIP) © 2001

CAW TCA CANADA

CARACTÉRISTIQUES

Admissibilité

Vous devez répondre à la définition *d'invalidité totale* et être dans l'incapacité de travailler pendant une période de *14 jours civils consécutifs*. Les indemnités sont payables dès le 15e jour consécutif d'une invalidité totale certifiée au moyen de preuves médicales que la Great-West Life juge satisfaisantes.

En vertu du contrat d'assurance invalidité de courte durée:

«*Invalidité totale*» signifie que vous êtes dans l'incapacité, par suite d'une blessure corporelle d'origine accidentelle ou d'une maladie, d'exercer *toutes* les fonctions relatives à votre propre travail; *ET* que vous ne travaillez pas dans un but lucratif.

Les indemnités d'invalidité de courte durée admissibles sont payées à toutes les deux semaines en arriéré.

En vertu de l'assurance emploi:

L'assurance emploi est un programme gouvernemental. Si votre invalidité totale est susceptible de durer jusqu'à la période d'assurance-emploi relativement à la demande de règlement d'invalidité, Canadian Benefits vous fournira les formulaires de demande de prestations d'assurance-emploi appropriés.

En vertu du contrat d'assurance invalidité de longue durée:

Au cours des *24 PREMIERS MOIS* où vous recevez des indemnités d'invalidité de longue durée, par «*invalidité totale*» il est entendu que vous êtes incapable, par suite d'une blessure corporelle d'origine accidentelle ou d'une maladie, d'exercer toutes les fonctions relatives à votre propre occupation; *ET* que vous n'exercez aucune occupation lucrative; *ET* n'êtes pas incarcéré dans un pénitencier ou toute autre maison de correction, par suite de condamnation pour infraction criminelle ou autre délit.

La définition *d'INVALIDITÉ TOTALE* change après que vous avez reçu des indemnités d'invalidité de longue durée pendant une période de **vingt-quatre mois consécutifs**; par la suite, vous devez être dans l'INCAPACITÉ TOTALE d'exercer *toute occupation lucrative* pour laquelle vous êtes raisonnablement qualifié en raison de votre instruction, de votre formation ou de votre expérience; ET ne pas travailler, à quelque moment que ce soit, dans un but lucratif (sauf dans le cadre d'un emploi aux fins de réadaptation approuvé par la Great-West Life); ET ne pas être incarcéré dans un pénitencier ou toute autre maison de correction, par suite de condamnation pour infraction criminelle ou autre délit.

Les indemnités d'invalidité de longue durée sont payées mensuellement en arriéré.

Régime de pensions du Canada/régime de rentes du Québec:
Vous devez soumettre une demande de prestations de maladie en vertu du Régime de pensions du Canada ou du Régime de rentes du Québec, lorsque la Great-West Life en exprime le désir. Si vous avez été frappé d'invalidité avant le 1er juin 1996, 100 % de tout montant qui vous est alloué (à l'exclusion des sommes reçues en vertu du RPC/RRQ pour vos enfants à charge) *serviront à réduire* les indemnités d'invalidité de longue durée payables en vertu du régime collectif d'assurance revenu en cas d'invalidité Pour ce qui est des membres qui ont été frappés d'invalidité après le 1er juin 1996, une réduction RPC/RRQ RPC/RRQ de 90 % à été négociée avec la compagnie d'assurance afin qu'il soit tenu compte du fait que

bien que les versements en vertu du régime collectif d'assurance revenu en cas d'invalidité ne soient pas imposables, les prestations RPC/RRQ sont imposables.

Les formulaires de demande de prestations de maladie en vertu du Régime de pensions du Canada ou du Régime de rentes du Québec **(RPC/RRQ)** sont détenus par l'administrateur du régime. Celui-ci les expédiera aux membres, le cas échéant.

Si ces prestations vous sont refusées, vous devez, si la Great-West Life en exprime le désir, appeler de cette décision. **Veuillez noter que le fait de recevoir des prestations RPC/RRQ durant votre invalidité totale et permanente à un effet positif sur votre pension de retraite RPC/RRQ.**

Versement des indemnités

Pour remplir les conditions de la définition d'invalidité totale, vous devez recevoir régulièrement les soins d'un médecin ayant les compétences requises pour soigner votre invalidité. Vous devez également suivre le traitement qui est recommandé par le médecin et qui, conformément aux techniques médicales ordinaires, convient à la cause et à la nature de l'affection occasionnant l'invalidité. Si ces conditions ne sont pas remplies et que des preuves médicales objectives ne soient pas soumises à l'appui de votre demande de règlement, aucune indemnité ne sera versée en vertu du régime.

C'est toujours au membre qu'il incombe de satisfaire aux exigences relatives à sa demande de règlement en vertu du régime collectif d'assurance revenu en cas d'invalidité.

Preuve médicale:

Afin de mieux satisfaire aux besoins de nos membres, l'administrateur du régime à retenu les services d'un conseiller médical, qui oeuvrera à l'intérieur de 1'entreprise. Le conseiller médical de Canadian Benefits prêtera son concours au personnel de façon qu'il puisse mieux servir les membres. Par exemple, dans certains cas, le conseiller de l'administrateur du régime communiquera directement par téléphone avec votre médecin pour résoudre un probième touchant votre demande de règlement. Quelquefois, cette ligne de conduite élimine toute correspondance inutile et permet une prise de décision plus rapide quant à votre demande de règlement, qu'il s'agisse d'un dossier déjà ouvert ou d'un nouveau dossier.

Alcoolisme et toxicomanie:

Les dispositions de votre régime stipulent expressément que dans le cas d'alcoolisme, de toxicomanie ou d'autre troubles similaires, aucun versement ne sera effectué sauf dans les cas suivants

1. le membre est confiné dans un hôpital ou autre établissement autorisé à fournir des soins et traitements aux toxicomanes et aux alcooliques et reçoit régulièrement les soins d'un médecin, ou bien
2. il participe régulièrement à un programme de réadaptation contrôlé par un médecin et approuvé par écrit par La Great-West Life.

Programme de retour au travail modifié:

Les régimes d'invalidité de courte durée et de longue durée offrent un programme de retour au travail modifié aux membres qui sont dans l'incapacité de reprendre à temps plein leur travail antérieur immédiatement après avoir reçu des indemnités en vertu du régime collectif d'assurance revenu en cas d'invalidité. Le programme de retour au travail modifié est destiné à vous permettre de reprendre à temps plein la même occupation que vous exerciez auprès de l'entreprise avant votre invalidité.

Si vous jugez que vous pourriez participer à un tel programme alors que vous recevez des indemnités en vertu du régime collectif d'assurance revenu en cas d'invalidité, veuillez en discuter avec l'expert chargé de votre dossier et communiquer avec le président/fiduciaire de votre région afin de confirmer que le programme de retour au travail modifié est offert dans votre région. Canadian Benefits, la Great-West Life ou son représentant pourraient entrer en contact avec vous afin de discuter des restrictions et(ou) modifications relatives à votre occupation et horaire, vous donner des renseignements sur les raisons, le fonctionnement et l'emplacement de ce genre de programme et répondre à toute question que vous pourriez avoir à ce sujet. Votre médecin devrait être mis au courant par écrit ou par téléphone. Afin que des indemnités partielles soient versées en vertu de votre régime durant un retour au travail dans le cadre d'un programme de réadaptation, la compagnie d'assurance doit approuver le programme. Dès que la Great-West Life approuve le programme, vous recevrez des indemnités pour la période au cours de laquelle vous êtes dans l'incapacité de travailler en soumettant le nombre de vos heures de travail à l'administrateur du régime. Les versements en vertu du régime collectif d'assurance revenu en cas d'invalidité sont calculés en fonction du pourcentage de votre horaire de travail. Par exemple, si vous travaillez 60 % de votre horaire régulier, le régime versera 40 % de vos indemnités régulières.

Les contributions (primes) sont exonérées pendant que vous participez à un programme de retour au travail modifié approuvé en vertu de l'assurance. Toutefois, si des contributions sont déduites de votre salaire, veuillez vous reporter aux pages de la brochure relatives au remboursement.

Imposition

Étant donné que vous versez les primes de votre régime d'assurance invalidité, toutes indemnités payables en vertu du régime ne sont pas imposables et aucun relevé T4A n'est établi.

Vos prestations RPC/RRQ représentent toutefois un revenu imposable et vous en êtes responsable. **Les prestations RPC/RRQ (à l'exclusion de toutes prestations payables pour ce qui est des enfants à charge) servent à réduire vos indemnités en vertu du régime collectif d'assurance revenu en cas d'invalidité.Si vous êtes frappé d'invalidité totale après le 1er juin 1996, seulement 90 % de vos prestations RPC/RRQ serviront à réduire vos indemnités en vertu du régime.**

Demandes de règlement en vertu de la Commission de la santé et de la sécurité du travail (CSST):

Si votre invalidité résulte **d'un accident ou d'une maladie de nature professionnelle**, conformément aux modalités du régime collectif d'assurance revenu en cas d'invalidité, vous devez faire une demande de règlement auprès de la CSST. Il vous faut également faire une demande de règlement auprès de la CSST lorsqu'il à été déterminé que l'invalidité totale est causée par un stress de nature professionnelle. Votre représentant syndical pourrait vous prêter son concours dans une telle situation. Si la CSST refuse votre demande de règlement, vous êtes censé faire opposition à cette décision.

En vertu du régime collectif d'assurance revenu en cas d'invalidité, aucune indemnité n'est payable pour toute invalidité résultant d'une maladie ou blessure de nature professionnelle avant la réception d'une confirmation qu'une demande de règlement à été faite auprès de la CSST, étant donné que c'est la CSST qui paye en premier. Le régime offre un PRÉFINANCEMENT dans le cas où votre demande de règlement auprès de la CSST est en suspens, à condition toutefois que vous promettiez de repayer le régime si vous recevez un versement de la CSST, pour la même période, et de faire opposition à la décision de la CSST lorsque la compagnie d'assurance en exprime le désir.

Préfinancement Si vous avez soumis une demande de règlement auprès de la CSST et que vous ayez besoin d'une aide financière en attendant que la CSST prenne une décision, vous pouvez recevoir une aide financière en vertu du régime collectif d'assurance revenu en cas d'invalidité si les renseigr.ements médicaux soumis établissent le bien-fondé de l'invalidité totale. En d'autres termes, le régime vous avancera les fonds pendant que vous attendez la décision de la CSST ou faites opposition à cette décision. Pour bénéficier d'un préfinancement. les conditions suivantes doivent être remplies

- au cours des 90 jours suivant la date du début de votre invalidité, vous avez soumis à Canadian Benefits un formulaire de demande de règlement en vertu du régime collectif d'assurance revenu en cas d'invalidité;
- vous devez fournir des preuves médicales établissant votre invalidité totale;
- vous devez remplir et signer a) un formulaire de cession permettant que les fonds qui vous seraient avancés en cas d'approbation de votre demande par la CSST, soient récupérés en vertu du régime collectif d'assurance revenu en cas d'invalidité; b) un formulaire permettant à la CSST de divulguer à l'administrateur du régime ou à la compagnie d'assurance des renseignements à votre sujet; c) une convention de remboursement stipulant que vous rembourserez tout montant qui vous à été avancé en vertu du régime collectif d'assurance revenu en cas d'invalidité, si votre demande de règlement est approuvée.

Si la CSST refuse votre demande de règlement, il vous faudra soumettre, en vertu du régime collectif d'assurance revenu en cas d'invalidité, une copie de sa lettre accompagnée d'une copie de la demande d'appel,le cas échéant. Si, après le versement des prestations de la CSST et la fermeture de votre dossier, vous ne pouvez reprendre le travail, un formulaire d'autorisation permettant à la CSST de divulguer les renseignements médicaux doit être soumis en vertu du régime. Sans ce formulaire d' autorisation, votre demande de règlement ne pourra être prise en considération en vertu du régime.

Demande de règlement à un tiers (subrogation):

Si, par suite d'un accident de voiture automobile ou de tout autre accident/incident ayant contribué en totalité ou en partie à votre invalidité totale et relativement auquel des indemnités ont été versées en vertu du régime, vous avez droit à un règlement aux fins de dédommagement pour perte de salaire, la Great-West Life se réserve le droit de récupérer le montant des indemnités qui vous ont été versées au cours de cette période. **Cette somme sera déposée dans votre régime.**

Autrement dit, si vous êtes dédommagé par un tiers, vous devez rembourser à la Great-West Life (l'assureur) les indemnités qui vous ont été versées en vertu du régime afin que celles-ci soient déposées dans le régime. Le remboursement que vous faites en vertu du régime n'est pas subordonné à un règlement spécifique pour perte de salaire. En d'autres termes, si vous avez accepté un règlement quelconque, il sera reconnu comme étant un règlement tout compris, comportant la perte de salaire, et les fonds qui vous ont été avancés devront être remboursés en vertu du régime.

Pour toute question touchant le règlement des sinistres, il est important de communiquer directement avec l'administrateur du régime. L'adresse et les numéros de téléphone de Canadian Benefits figurent au début de cette brochure relative au régime collectif d'assurance revenu en cas d'invalidité. Le personnel de Canadian Benefits se fera un plaisir de vous prêter son concours et de satisfaire à vos besoins. Les demandes d'appel relativement au règlement des sinistres et toutes questions que vous pourriez avoir, peuvent être dirigées à votre fiduciaire régional.

LE CONSEIL DES FIDUCIAIRES
TCA local 2213
Fonds de Fiducie Santé et Bien-Être
Police collective no 328802

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The
Great-West Life
ASSURANCE COMPANY

January [illegible]

Dear

Re:
Group Plan Number
Employee ID Number

We have received a copy of the declination letter from Canada Pension Plan.

Since medical information received supports your inability to work, it should also satisfy Canada Pension Plan's definition of total disability. We recommend that you appeal their decision.

Instructions for appealing this decision are included in their letter. Please advise us by telephone or letter if you would like Great-West Life to send the medical information on file directly to Canada Pension Plan to assist with your appeal.

If we do not hear from you within three months regarding the status of your appeal, we will estimate the Canada Pension Plan disability benefits you may be eligible to receive and deduct them from your current disability benefits.

If you have any questions, please call me at or toll free at

Sincerely,

Disability Claims Specialist

Sun Life
Group Disability Management

April 2009

Dear Mr

RE: **Name of Claimant:**
Contract Number:
Control Number:

Your letter has been referred to me for reply and I have reviewed Mr claim file as well as the policy provisions.

It is our position that Mr has a duty to mitigate his losses by making all reasonable efforts to apply for and obtain CPP disability benefits. In this regard, we assert that any expenses incurred to establish eligibility for CPP benefits are his responsibility.

Furthermore, we [illegible] agree with your assertion that the benefit of a favourable decision from the Review Tribunal would accrue only to [illegible] and not to Mr under the provisions of the policy. Sun Life will only deduct the amount of the initial award from its monthly benefit thereafter. As such, Sun Life does not adjust its benefit to deduct the annual increases in the CPP disability benefit. Mr would therefore be entitled to the entire increase in benefit.

The amount of Mr CPP retirement pension is calculated based on his contributions to the plan while working. Should Mr not pursue his application for disability benefits with CPP the amount of his pension will be adversely affected by the fact that he will not have contributed to the fund for several years. It is our understanding that this penalty is greatly reduced if he is in receipt of CPP disability benefits.

This being said, although Dr report was not included with your letter, we recognize that Mr health may make it difficult for him to attend the hearing. As such, we are willing to consider funding a portion of his legal fees. Although you have provided Sun Life with confirmation of your billing schedule, we would appreciate receiving an estimate of the hours and costs expected on this case.

I will provide you with a final decision as soon as we have received the above information.

Yours truly,

CLARICA

Canada Pension Plan ("CPP") Agreement

Name: Policy Certificate:

You are responsible under your plan to apply for CPP benefits and to keep Clarica Life Insurance Company ("Clarica") informed of your application as well as any [illegible]. Please read this Agreement carefully, sign it, and return it to us at the following address:

I understand the Plan requires me to apply for disability benefits payable under CPP and that any CPP benefits that I am entitled to receive, reduce directly any long term disability ("LTD") payable to me under the Plan. I also understand that this reduction applies both to LTD benefits I received before my CPP entitlement was determined, as well as to LTD benefits payable after.

Therefore, in consideration of paying unreduced LTD benefits for any period during which I may be entitled to CPP benefits I agree to the following terms:

1. I will apply for CPP benefits and will immediately notify [illegible] of the CPP decision.
2. I will provide **Clarica** with any CPP [illegible] received from the CPP office.
3. If my application is [illegible], I will [illegible] the [illegible] within [illegible] days of being [illegible] by **Clarica** to do so.
4. I will sign the enclosed [illegible] form from the CPP Office, "[illegible] and Payment of Canada Pension Plan Disability [illegible] to an Administrator of a Disability Income Program", and return it to **Clarica** along with this Agreement form.
5. I agree that within 10 days from the date I receive payment from CPP, I will reimburse **Clarica** in a lump sum, for all payments it has advanced to me related to CPP which have not been reimbursed directly to **Clarica** by CPP.
6. If I do not comply with any of the terms of this Agreement, I agree that **Clarica** has the right to withhold or reduce my LTD benefits, until the amount of CPP disability benefits to which I may be entitled has been exhausted.

This agreement shall bind my heirs, executors, administrators and assigns.

☐ I confirm that I applied for CPP disability benefits on ________ at ________

OR

☐ I confirm that I appealed the [illegible] ________ at ________

Signature ________ Date ________

Witness ________ Date ________

NOTE: If this agreement is not returned to Clarica within 2 months of being requested, your LTD benefit payments may be reduced by an estimate of the amount of benefits to which you may be entitled under the Canada Pension Plan.

CLAIM A

The

Great-West Life

[illegible]

November [illegible], 199[illegible]

Dear Mr

RE: [illegible]

Group Plan Number
Employee ID Number

Thank you for notifying us of your declination from Canada Pension Plan for disability benefits.

Since medical information received supports your inability to work, we believe that it should also satisfy Canada Pension Plan's definition of total disability. We recommend that you appeal their decision.

Instructions for appealing this decision are included in their letter. Please advise us by telephone or letter if you would like Great-West Life to send the medical information on file directly to Canada Pension Plan to assist with your appeal.

If we do not hear from you within three months regarding the status of your appeal, we will estimate the Canada Pension Plan disability benefits you may be eligible to receive and deduct them from your current disability benefits.

If you have any questions, please call.

Sincerely,

Disability Claims Specialist

Sun Life

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

September 23,1999.

Director,
Appeals and Reconsideration,
Disability Benefits,
Canada Pension Plan,
Human Resources Development Canada
P.O. Box 2710 Main Station,
Edmonton, Alta. T5J 4C2

Dear Sir or Madam:

Re: CPP Disability Benefits

My application for Canada Pension Plan disability benefits dated January 99 was reviewed and denied.I talked this decision over with my physician who deals with CPP disability benefits on a daily basis as a consultant with the W.C.B. and he advised my not to appeal your decision. I informed the company carrying my LTD-Sun Life- of your decision and my reason not to appeal. Please note the attached letter from Sun Life suggesting I file an appeal -that is the reason I am requesting an appeal.

Thank you for your consideration of the above and I am sorry to have to waste your valuable time on such.

Yours Truly,

Sun Life

Contract No.:
Employee I.D.:

Seq. No.:
Control No.:

Ontario Teachers Insurance Plan
Long Term Disability Insurance
Claims Services Unit

[illegible]

Subject: Long Term Disability

Dear

Thank you for sending us a copy of the decision letter from the Canada Pension Plan.

Since medical information received supports your inability to work, we believe that it should also satisfy Canada Pension Plan's definition of total disability. We recommend that you appeal their decision.

Instructions for appealing this decision are included in the CPP denial letter. Please call me if you require any assistance in appealing the Canada Pension Plan decision. At your request, OTIP/RAIO will send the medical information on file directly to Canada Pension Plan to assist with your appeal.

Please keep us informed of any progress with your appeal. If we do not hear from you within three months regarding the status of your appeal, we will terminate the Canada Pension Plan disability benefits you may be eligible to receive and deduct them from your current disability benefits.

If you have any questions or concerns, please do not hesitate to contact me at (519) 884-[illegible] or 1-800-[illegible], ext. 345.

Sincerely,

[illegible], Benefits Assistant

The Mutual Group

October [illegible] 199[illegible]

CANADA PENSION PLAN ("CPP") AGREEMENT

Name: [illegible]

[illegible] Mutual Life Assurance Company of Canada ("Mutual") [illegible] Please read this Agreement carefully, sign it, and return it [illegible]

I understand that the Plan requires me to apply for disability benefits payable under CPP and that any CPP benefits that I am entitled to receive [illegible] directly any long term disability ("LTD") payments to me under the Plan. I also understand that this [illegible] applies both to LTD benefits I received before my CPP entitlement was determined, as well as to LTD benefits payable after.

Therefore, in consideration of paying unreduced LTD benefits for any period during which I may be entitled to CPP benefits I agree to the following terms:

1. I will apply for CPP benefits and will immediately notify Mutual of the CPP decision.
2. I will provide Mutual with any CPP [illegible] received from the CPP office.
3. If my application is denied, I will appeal the denial within [illegible] days of being requested by Mutual to do so.
4. I will sign the enclosed [illegible] form from the CPP Office "[illegible] Canada Pension Plan Disability [illegible]", and return it to Mutual [illegible]
5. I agree that within [illegible] days from the date I receive payment from CPP, I will reimburse Mutual in a lump sum for all payments [illegible] directly to Mutual by CPP.
6. If I do not comply with any of the terms of this Agreement, I agree that Mutual has the right to withhold or reduce my LTD benefits until the amount of CPP [illegible] to which I may be entitled [illegible]

This agreement shall bind my heirs, executors, administrators [illegible]

☐ I confirm that I applied for CPP disability benefits on

[illegible] 19________

OR

☐ I confirm that I appealed the denial decision on

[illegible] 19________

____________________ ____________

Signature Date

____________________ ____________

Witness Date

NOTE: If this agreement is not returned to Mutual Life of Canada within 2 months of being requested, your LTD benefit payments may be reduced by an estimate of the amount of benefits to which you may be entitled under the Canada Pension Plan.

The
Great-West Life
[illegible]

November [illegible], 199[illegible]

Dear

RE:
Group Plan Number
Employee ID Number
London District Catholic School Board

This is in reference to your Long Term Disability benefit.

We have received partial reimbursement from the Workplace Safety & Insurance Board for their acceptance of your claim for the period Great-West Life paid benefits to you.

Therefore, we have recalculated your monthly benefit effective which was the date you first received payment from Great-West Life for your Long Term Disability benefits.

Under the provisions of your group plan, your monthly maximum benefit amount is $[illegible]. Since you are in receipt of WSIB benefits in the amount of $1,555.49, all monies paid to you from Great-West Life while you were in receipt of WSIB benefits must be recovered.

For the period we have paid you $[illegible]. We have deducted $3,551.44 representing your Canada Pension Plan disability benefit which you are currently not in receipt of, which leaves an overpayment balance in the amount of $9,[illegible]. WSIB has reimbursed us in the amount of $4,[illegible]. Therefore, an outstanding balance of $[illegible] remains outstanding.

Please send a cheque payable to Great-West Life Assurance Company in the amount of $[illegible] as soon as possible.

Your current monthly Long Term Disability benefit is as follows:

LTD	$1,[illegible]
Less WSIB	$1,555.49
Net Benefit Payable	0.00

Annexe "B"

Great-West Life

August 4, 1992

Dear

RE: Group Policy Number

This is in reference to your Long Term Disability claim.

Under the provisions of this group plan, Long Term Disability benefits commence following a waiting period of 26 weeks. During this waiting period and the next 24 months, you are considered disabled if illness or injury prevents you from performing the duties you regularly perform for the employer before disability started. After this initial 50-month period of 24 months, you are considered disabled if illness or injury prevents you from performing the regular duties of any occupation for which you have at least the minimum qualifications.

At the present time, based on the medical information on file, you are considered unable to perform the duties of your regular job. We would like to point out, however, that your claim remains under review. That is, we will require updated medical documentation throughout the duration of your claim for our ongoing assessment of your continued entitlement to benefits. You will be notified should there be any change regarding the status of your claim.

The waiting period commenced on July 3, 1992 and was satisfied July 2, 1992. Your Long Term Disability benefit cheque will cover the monthly period from the 1st of the previous month to the 2nd of the month of issue. Your first cheque covering the period July 3, 1992 to August 2, 1992 inclusive has now been released. This cheque is in the amount of $0.00 as you are still in receipt of sick leave benefits. Subsequent cheques will be issued on approximately the 22nd day of each month.

The gross benefit for which you are insured is 60% of your pre-disability monthly earnings. Your gross monthly benefit is $0.00. Benefits will continue at this amount provided you are in an other reportable income, as outlined in the transcript of the interview mailed to you for signature. Other income is either directly subtracted from the gross Long Term Disability benefit or it is coordinated with your Long Term Disability benefit.

Annexe "C"

Company Complaint Data Reporting Form

Company Name: _____

Contact Name: _____ Phone number: _____

Ombudsman Liason Officer: _____

Fax Number: _____ E-mail Address: _____

Reporting Period: 1st Quarter / 2nd Quarter / 3rd Quarter/ 4th Quarter Year
(circle Quarter)

Please complete the following breakdown of complaints received during the period -

	Function							
	Under-writing &Rating	Marketing & Sales	Sales Intermed-iaries	Claims	Policy - Owners Services	Product	Micell-aneous	Total
Line of Business								
Automobile								
Property & Liability								
Accident & Sickness/ Disability/Health								
Individual								
Group								
Creditor								
Total A&S								
Travel								
Individual								
Group								
Creditor								
Total Travel								
Life								
Individual								
Group								
Creditor								
Total Life								
Investments Annuities/Variable								
Insurance Contracts								
Total Complaints								

Information submitted in confidence to the Financial Services Commission of Ontario's Office of the Insurance Ombusman

Annexe "D"

Consumer Assistance Centre

2000 ANNUAL REPORT

Canadian Life and Health Insurance Association Inc.

Association canadienne des compagnies d'assurances de personnes inc.

TORONTO / MONTRÉAL / OTTAWA

1 Queen Street East
Suite 1700
Toronto, Ontario
M5C 2X9

Tel: [416] 777-2221
Fax: [416] 777-1895
www.clhia.ca

1, Rue Queen Est
Bureau 1700
Toronto (Ontario)
M5C 2X9

Tél. : [416] 777-2221
Fax : [416] 777-1895
www.accap.ca

Canadian Life and Health Insurance Association Inc.

Association canadienne des compagnies d'assurances de personnes inc.

Consumer Assistance Centre
2000 ANNUAL REPORT

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"Thank you for listening."

That's what we hear every day at the Consumer Assistance Centre of Canada's life and health insurance industry.

We listen and we answer your questions about life and health insurance.

No matter where you are in Canada, our experienced counsellors with years of insurance industry experience are only a phone call away. We can talk to you about life and health insurance products and services, provide insurance and financial planning publications and policy search assistance, and help with concerns or complaints. Give us a call. We'll be glad to help.

Consumer Assistance Centre

1-800-268-8099 (English) **1-800-361-8070** (French)

www.clhia.ca

Consumer Assistance Centre Profile

What is the Consumer Assistance Centre (CAC)?

The life and health insurance industry's Consumer Assistance Centre is a national consumer help service available in both English and French. It operates out of the Canadian Life and Health Insurance Association Inc. (CLHIA) offices in Toronto and Montreal, and is accessed by consumers through toll-free telephone lines which account for most contacts; electronic mail, now the source of most written requests for information and assistance; traditional mail; faxes; and in person.

Since its inception in 1973, the CAC has handled more than 900,000 calls, providing assistance to Canadians of all ages, from all walks of life, from all across the country.

Consumers are by far the predominant source of calls (more than 90 per cent). But agents, brokers and insurance companies also use the CAC as a central source of timely and accurate industry information.

What services are provided?

The CAC handles an average of nearly 62,000 calls per year, most of them from policyholders and other consumers.

Callers request:

- **information** about life and health insurance products and services, company addresses and phone numbers;
- copies of **publications** on life and health insurance products and services and financial/retirement planning;
- **policy search assistance,** or help locating life insurance policies that may have been misplaced;
- **information about CompCorp,** the organization that runs the industry's consumer protection plan;
- information about how **Holocaust victims and heirs** can search for lost insurance proceeds (special service); and
- in a very small number of cases, **assistance in pursuing complaints.**

Who responds to the calls?

The CAC is staffed by counsellors with extensive industry backgrounds. Most are retired insurance company executives with in-depth expertise in many aspects of the industry, including claims, law and marketing.

These counsellors bring knowledge, patience and empathy to the task and draw upon the collective industry experience of the group to provide accurate, objective information to callers. When required, they can also call on the expertise of the numerous industry specialists at the CLHIA.

Consumer concerns or complaints

In a very small number of cases a caller raises a concern or complaint about some aspect of his or her relationship with a life and health insurance company. Such problems are often resolved during the first telephone contact, when counsellors provide background information on industry practices and guidelines and common operational procedures.

If the consumer wishes to pursue a complaint further, the CAC will bring the matter to the attention of the company President, in writing.

OmbudService

In keeping with the industry's commitment to meeting the needs of life and health insurance customers, an OmbudService was introduced in 1998 to enable consumers to pursue further outstanding concerns and complaints. This service provides consumers with access to an additional conciliation process and significantly strengthens the industry's ability to respond effectively to their problems, adding value to the CAC's complaint resolution capacity.

Holocaust support service

This dedicated toll-free telephone service, also established in 1998, helps locate unclaimed insurance proceeds that may be owed to victims and survivors of the Holocaust and their heirs.

Activity Highlights

Number of enquiries

In 2000, more than 56,000 people called the CAC, seeking information and assistance on almost 72,000 different topics. More than 90 per cent of the calls came from individual consumers.

Reasons for calls

More than half the calls involved requests for product information. Another 30 per cent were from consumers seeking information about life and health insurance companies. Together, these two categories accounted for more than 80 per cent of calls received by the CAC.

Almost 70 per cent of the product information enquiries concerned health insurance, whether travel/visitors to Canada or extended health and dental insurance.

Consumer publications

In 2000, the CAC distributed almost 20,000 consumer publications from the list of a dozen titles produced and kept up to date by the CLHIA and CompCorp. The most popular publications have to do with life, disability and travel insurance.

Policy searches

More than 1,800 people called during the year for help locating possible life insurance policies on deceased persons, or for advice on how to locate possible misplaced policies of their own. Policy searches were carried out in 117 cases, with a positive "find" ratio of 14 per cent.

Concerns or complaints

Of the 72,000 enquiries, a little more than 1000, or less than 1.5 per cent, involved concerns or complaints. CAC counsellors resolved or dealt with 572 at the initial point of contact.

A further 432 complaints moved forward to written status. By year end, the CAC had made an initial response to 258 of these. The remaining 174 had been referred to the Presidents of the companies in question for response.

OmbudService

In 2000, 17 consumers expressed interest in pursuing their complaints through the OmbudService, after completing the initial complaint resolution process. This brings to 44 the number of consumers who have sought the service's help since it was established in the fall of 1998. Of the 28 cases processed by the service (five are awaiting consumer authorization before proceeding and 11 policyholders eventually elected not to use the service), 26 files have been closed. Of these, the insurer's position was revised in favour of the consumer in six cases, or 23 per cent.

Advisory Board

In April 2000, the CLHIA enhanced the industry's CAC through the establishment of a seven-person Advisory Board with a view to maximizing the CAC's usefulness to consumers.

Requests for Information and Services

Volume of enquiries

In 2000, the CAC responded to 56,090 calls, down slightly from the previous year, as shown in Chart i. These calls involved almost 72,000 enquiries on individual topics.

Who called us?

The CAC's clientele consists first and foremost of consumers, who consistently make up more than 90 per cent of all callers, and in 2000 accounted for fully 93 per cent. Calls from agents, involving product enquiries, policy searches and company information, have averaged almost 6 per cent of total calls during the last three years. Enquiries from insurance companies, concerning industry guidelines and regulations and company information, typically represent a little more than 2 per cent of all calls.

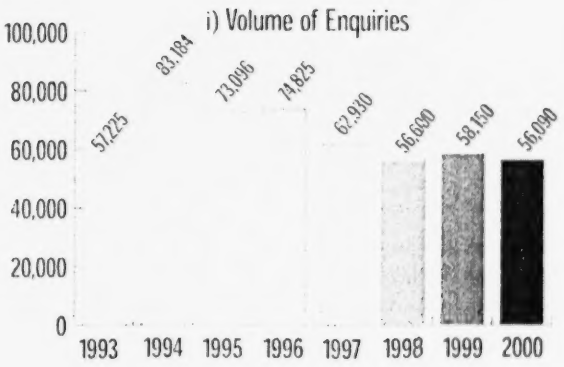
How did they hear of us?

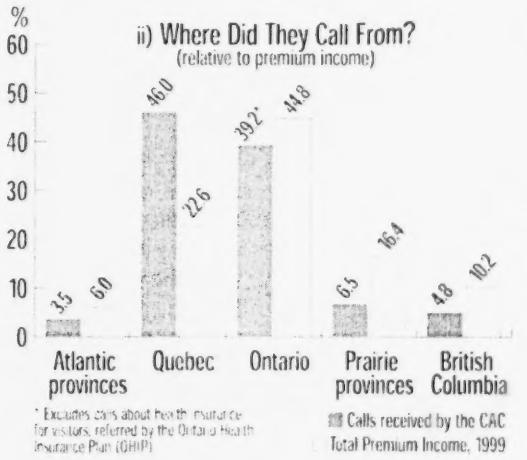
Callers learn of the CAC through a variety of sources, including agents, newspaper articles, government and constituency offices, insurance companies and other related trade and industry associations. Approximately one third of callers learn of the service through advertising in the regular white and yellow pages, and the electronic yellow pages of phone books, in 196 communities across Canada.

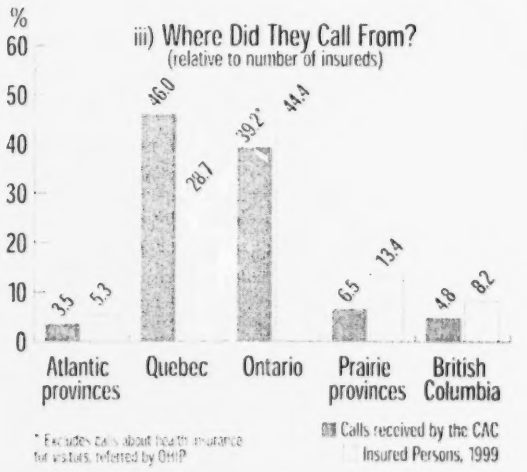
Where did they call from?

In general, the volume of calls tends to follow both the distribution of premium income and percentage of insureds across Canada. That more calls come from Quebec than any other province or region is mainly due to the fact that many Quebec government agencies routinely refer callers to the CAC. Chart ii shows the percentage of contacts from each region alongside the percentage of total premium income from the same region, based on 1999 statistics.

When the regional distribution of calls is compared to the percentage of persons insured under life and health insurance policies, as in Chart iii, the gap tends to narrow somewhat in all regions.







Why did they call us?

In the course of 56,090 calls to the CAC last year, 71,889 individual topics were addressed, which is to say that callers often raised more than one topic.

Chart iv shows that more than 53 per cent of the topics raised related to requests for generic information about life and health insurance products, including policy provisions and exclusions, along with questions about distribution.

The following analysis, which provides additional detail about callers' reasons for contacting the CAC, is also based on the number of topics raised.

Product information

Almost 70 per cent of the product information enquiries concerned health insurance, whether related to travel and/or visitor to Canada or extended health care and dental insurance.

The year-over-year increase in the volume of travel health enquiries, as shown in Chart v, is due to changes in policy provisions and increased rates in a number of individual travel plans in 2000, primarily as the result of rising health care costs in the U.S.

The gradual increase in enquiries involving disability insurance parallels a similar rise in the volume of claims for these products, as noted in *Canadian Life and Health Insurance Facts,* the industry statistical publication.

Although travel and extended health insurance are sold on both an individual and group basis, it is estimated that 95 per cent of enquiries to the CAC are from consumers who are interested in purchasing such coverage on an individual basis, and require general information about providers, underwriting and policy provisions.

Company information

Chart vi shows that nearly 88 per cent of company information enquiries involved requests for telephone numbers and addresses and other queries of a general nature. Many of these requests were due to consumers' need for clarification as a result of industry merger and acquisition activity. Product information requests, at almost 9 per cent, involved queries about various products offered by specific companies, as opposed to generic product enquiries, which are dealt with above under "Product information."

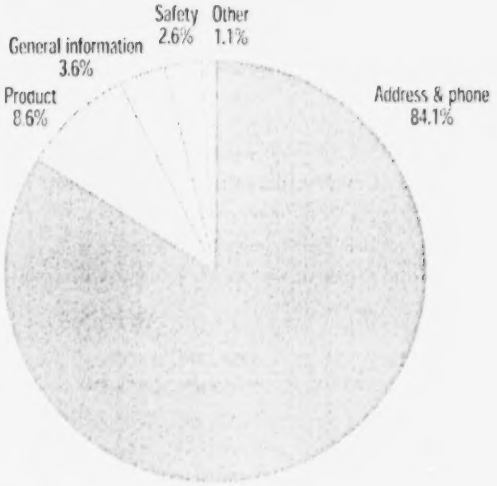
Booklet requests

The CLHIA produces a variety of consumer publications providing information, guidance and tips on the range of insurance company products and services available. The cost of production is borne by the industry. Single orders are free; a small fee is charged for bulk orders, to cover shipping charges.

The CAC distributed some 20,000 booklets in 2000, down about 8 per cent from the previous year. Requests for CompCorp booklets were for the most part bulk orders received from insurance companies and brokerages, while requests for CLHIA publications usually involved single copy orders from consumers.

The CompCorp booklet accounted for more than 50 per cent of the publications distributed in 2000. Booklets on life and disability insurance accounted for about 21 per cent; travel health insurance, about 8 per cent; retirement planning, 2 per cent; and other publications, about 18 per cent.

vi) Company Information



Consumer publications include:

Life	A Guide to Buying Life Insurance
Health	A Guide To Health Insurance (new in the summer of 2001) Disability Insurance: Where Will the Money Come from if You're Disabled? Health Insurance for Travellers: What you should know before leaving Canada
Retirement Planning	Retirement: As You'd Like It Consumer Tips: RRSPs with Life Insurance Companies
Financial Planning	Consumer Tips: Segregated Funds The Shoe Box Guide – Personal and Family Documents: What and Where are They?
Other	Canadian Life and Health Insurance Facts The Life and Health Insurance Consumer Assistance Centre
CompCorp	Consumer Protection Plan for Canadian Life and Health Insurance Policyholders

Policy searches

In 2000, the CAC received 1,821 requests from individuals either pursuing possible life insurance coverage of recently deceased persons or looking for possible misplaced policies of their own. In 117 of these cases, sufficient evidence existed to carry out formal policy searches. Sixteen policies were discovered, resulting in a positive "find" ratio of almost 14 per cent, which compares favorably with previous years.

Policy searches are conducted by both CLHIA member companies, and former member companies which contribute financially to the operations of the CAC. Requests come from heirs, beneficiaries, executors and law enforcement agencies. In 2000, 22 of the 117 requests resulted from police investigations.

CompCorp

Questions related to CompCorp came mainly from consumers who wished to confirm insurers' membership in the consumer protection plan and to clarify CompCorp guarantees for various products. More than 58 per cent of the product enquiries related to retirement products.

The number of enquiries concerning CompCorp declined from 2,301 in 1999 to 1,367 in 2000, no doubt reflective of consumer confidence in the safety of the industry.

Other

The "Other" category includes requests for general industry information and for assistance locating government services or departments.

Complaint resolution

In 2000, as shown in Chart vii, the CAC received a total of 1,004 consumer concerns or complaints, representing 1.4 per cent of the almost 72,000 enquiries. These were submitted either in writing (258 letters) or over the phone (746 calls).

Of the 746 complaints discussed over the phone, 572 or almost 77 per cent, were either resolved by the counsellor during the initial telephone contact or the consumer elected not to pursue the matter further by writing to the CAC. In the remaining 174 telephone complaints, about 23 per cent, the consumers proceeded to submit their concerns in writing.

In total, the CAC received 432 written requests for assistance and as of year end, 26 of these were still pending and 232 had been responded to by the CAC, which provided explanatory information or requested further information in order to formulate the best possible response.

The remaining 174 written requests for assistance were referred to the Presidents of the companies in question for review and a response sent directly to the consumer. Of these, 36 were still under review at time of writing. Of the 138 completed cases, the companies involved either provided additional information or modified their positions in favour of the consumer in 109 cases or 79 per cent, and maintained their positions in 29 cases or 21 per cent.

Analysis of written complaints

Distribution of complaints by region

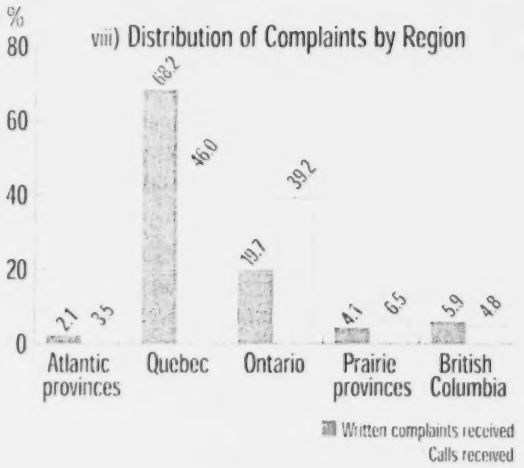
In 2000, as a new service, the CAC began analyzing the distribution of written complaints by the region in which they originated.

As Chart viii shows, in the Atlantic and Prairie provinces and in British Columbia, the percentage of complaints was roughly commensurate with the percentage of total calls. In Ontario, the percentage of complaints was about half the percentage of total calls.

In Quebec, the high number of complaints relative to calls is likely due to the fact that the Superintendent of Insurance and Financial Services Bureau routinely refer consumers with complaints involving life and health insurance to the CAC as a matter of government policy.

vii) Complaints

viii) Distribution of Complaints by Region



Complaints by company function

Complaints are classified according to the five main company functions detailed in Chart ix (one complaint can involve more than one function).

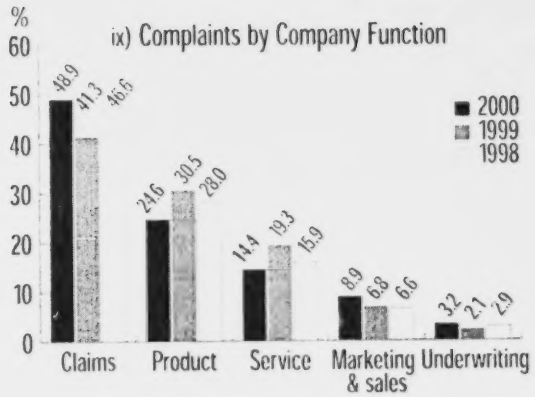
Historically, complaints involving claims-related issues have dominated. In 2000, they increased to almost 50 per cent of all complaints, while product- and service-related complaints declined.

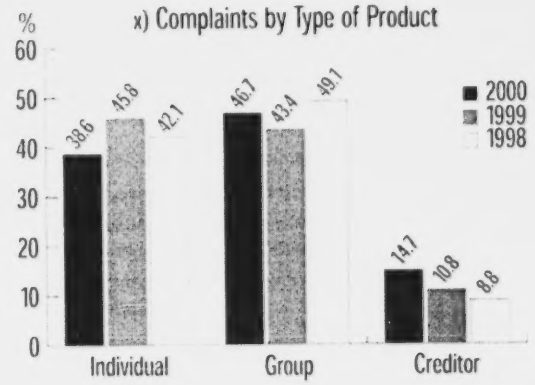
Complaints by type of product

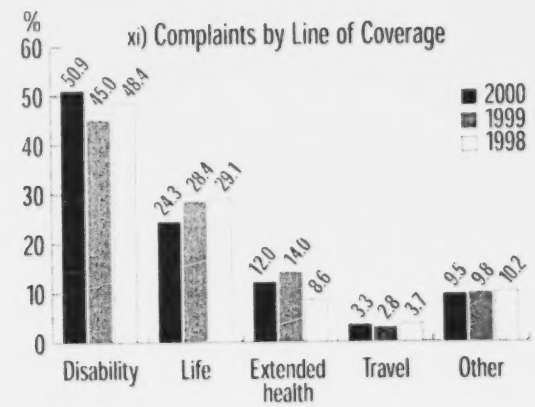
Most complaints involve either group or individual products. The decline in individual complaints shown in Chart x parallels the decline in life insurance product complaints noted in Chart xi, which most often involve individual insurance. The increase in group insurance complaints can be attributed to the rise in disability product complaints, which most often involve group insurance.

Complaints by line of coverage

Complaints involving disability products increased in 2000 after a gradual decline over the past two years, as shown in Chart xi. The decrease in complaints involving life insurance is in keeping with a similar decline in life insurance product enquiries (see page 5).







Life and disability

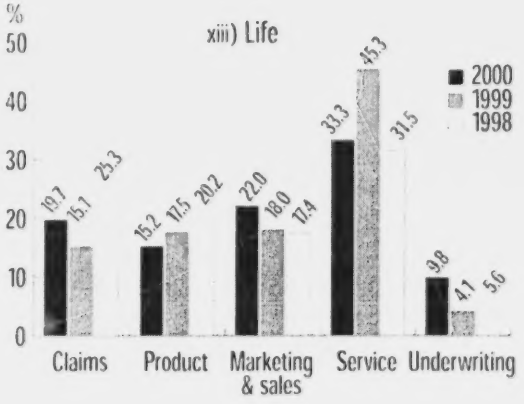
Further analysis of the predominant reasons for written complaints–disability and life insurance–follows.

As in past years, claims-related issues dominated complaints involving disability insurance, as Chart xii shows. In 2000 the majority of these claims-related complaints–more than 53 per cent–involved the denial or discontinuation of benefits under a group disability policy. Product-related complaints about disability insurance tended to centre on the definition of disability in the consumer's policy.

Turning to life, with the exception of service and underwriting, complaints tended to be evenly distributed over all aspects of the business. As is evident from Chart xiii, complaints about service-related issues declined markedly in 2000, paralleling a similar decline in service-related complaints related to all products (page 9).

Other lines of coverage

In the remaining line of coverage categories, most complaints about extended health coverage and travel health insurance involved claims, while complaints about "other" products, which include accident and sickness insurance and retirement products, tended to involve claims and service issues respectively.



Ombudservice

What is the OmbudService?

The OmbudService is an informal conciliation service for consumers who, having gone through the CAC's basic complaint resolution service, elect to pursue their concern or complaint further. The service is provided by trained and skilled OmbudService officers.

How does it work?

If on completion of the basic CAC complaint resolution process, a consumer wishes to pursue a matter further, they are provided with a letter and kit which, inter alia, ask for written details of the complaint and formal authorization of the OmbudService to discuss the case with the company.

An OmbudService Officer is assigned to review the information provided by the consumer. Through a series of discussions with the consumer and the company, the officer endeavours to find some "dry ground" between the two. This informal conciliation process offers the consumer an alternative to going to court to resolve a complaint.

OmbudService statistics

Of the 138 consumers whose complaints were reviewed at a senior level as the final step in the CAC's complaint resolution process last year, 17 or 12.3 per cent expressed an interest in pursuing the matter through the OmbudService and were sent information and authorization kits for review.

Most of these 17 OmbudService cases–almost 65 per cent–involved disability insurance products and 61 per cent centred on claims-related matters.

At year end, 10 of the 17 cases had been closed, while five were awaiting the consumer's authorization to proceed, and two were under review. Of the 10 cases closed, six were because the consumer elected not to proceed any further. Of the remaining four cases, the insurer's decision was revised in favour of the consumer in two cases and maintained in two.

Since inception

The OmbudService has received a total of 44 requests for assistance since September, 1998. Five cases are awaiting authorization from the consumer (as noted above), and in 11 cases, the policyholders elected not to pursue the matter.

Of the 28 cases handled by the OmbudService, two are currently under review. Of the 26 cases closed, the insurer's position was maintained and additional information provided to the consumer in 20 cases, while in six, or 23 per cent of cases, the insurer's position was modified in favour of the policyholder.

Holocaust Support Service

The CAC operates a dedicated, toll-free telephone service for anyone seeking information on insurance proceeds possibly owing to survivors of the Holocaust and Holocaust victims' heirs. The service was established in November, 1998, after a request for assistance from the Canadian Jewish Congress.

Although Canadian life insurance companies did not operate in continental Europe during the years 1930 to 1945, it is nonetheless possible that Canadian insurers operating in other countries, such as the United Kingdom, sold policies to people who subsequently became victims of the Holocaust.

The objective of the service is to put individuals in touch with such Canadian insurers, or with other organizations in other countries that help Holocaust survivors and the heirs of Holocaust victims locate unclaimed insurance policies on a worldwide basis.

One such organization, the International Commission on Holocaust Era Insurance Claims (ICHEIC), launched a toll-free North American call centre in February, 2000, dedicated to providing information and assistance resolving claims. As a result, the number of calls handled by the CAC's Holocaust support service has dropped from 160 in 1999 to 13 in 2000.

The CAC service has responded to 266 enquiries since inception. Of these, more than 50 per cent were from people who simply wanted to explore the possibilities, and 21 per cent were from individuals who wanted to enquire about possible unclaimed benefits from a specific carrier. The remaining calls were from people enquiring about the service itself (9 per cent); about compensation for other wartime losses, such as the wrongful death of a family member, imprisonment or forced labour (14 per cent); and about unclaimed bank accounts (4 per cent).

Advisory Board

In April, 2000, the CLHIA enhanced and strengthened the industry's Consumer Assistance Centre by establishing a seven-person Advisory Board under the Chairmanship of the Honourable Gilles Loiselle, former federal Minister of Finance. Other members of the Advisory Board are:

- Lea Algar, former Ontario Insurance Ombudsman;
- Bernard Bonin, former Senior Deputy Governor of the Bank of Canada;
- Sally Hall, former President of the Consumers' Association of Canada;
- Madeleine Plamandon, President and Director, Service d'aide aux consommateurs de Shawinigan;
- Yves Rabeau, Professor of Economics, Université du Québec à Montréal (UQAM);
- Reginald Richard, former Superintendent of Insurance for New Brunswick

The CAC Advisory Board and its two sub-committees convened on a total of three occasions in 2000 to provide guidance on the CAC's overall priorities, directions, service mix and performance with a view to maximizing its usefulness to consumers.